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ABSTRACT

An instructional program in patient education skills for primary care medical residencies is described, with six instructional modules included. The federally-funded program, developed by the University of Wisconsin, was designed to enable physicians to better communicate with their patients about health, disease, and treatment. The six modular learning units, which can be integrated throughout the 3 years of a primary care residency program, are as follows: communication and basic patient education skills; assessment of patient beliefs and understanding; short-term individualized plans for patients; patient education strategies for health promotion; long-term strategies in patient education (relating to chronic disease); and incorporating patient education in practice. Instructional approaches include seminars, individualized instruction, and direct observation of the resident's clinical skills. It was found that patient education should include informing patients about rationales for procedures and about diagnoses, and negotiating with patients to develop acceptable and suitable plans for care. Specific project activities and recommendations are considered. The six modules, which consist of 279 pages, include objectives, information on the role of the clinical faculty, evaluation forms, and instructions for observation and feedback. A bibliography is appended. (SW)

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INSTRUCTIONAL MODULES TO TEACH PRIMARY CARE RESIDENTS TO EDUCATE PATIENTS

EXECUTIVE SUMMARY

D.H.H.S. Contract No. 232-79-0026

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INSTRUCTIONAL MODULES TO TEACH PRIMARY CARE RESIDENTS TO EDUCATE PATIENTS

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of the Final Report

Covers Period of Performance
During
March 6, 1979 - March 5, 1981

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Instructional Modules to Teach Primary Care Residents to Educate Patients

PURPOSE OF THE CONTRACT

The purpose of the project funded by the Health Resources Administration, Contract No. 232-79-0026 was to develop an instructional program in patient education skills for primary care medical residencies. This instructional program is designed to systematically educate primary care physicians to better communicate with their patients about health, disease, and treatment.

Many medical schools and residencies do not include formal instruction in patient education skills. Prior to the development of the instructional modules sponsored by this contract, no guidelines or teaching manuals for teaching patient education were available in the United States. The development of a flexible instructional program in patient education is of benefit to training programs which lack the resources to develop their own instructional materials, yet are interested in producing graduates with skills in communication and patient education.

OVERVIEW OF THE INSTRUCTIONAL MODULES

Bartlett's listing of physician health education competencies, developed through a Delphi survey of health professionals and consumers, were used to identify content for the instructional modules. These competencies "are intended as the basis for the development of competency-based curricula to train medical students, residents and practicing physicians in primary care." (1)

A review of the literature on health and patient education, physician-patient interaction and patient perception of illness has added depth to the content for the instructional modules. Particularly important are works by Green(2)(3), Leventhal(4)(5), Ley(6) and Svarstad(7).

Patient education is an activity that runs throughout the entire medical encounter. While patient education certainly includes the clear provision of information and instruction in necessary skills, it also includes accurate gathering of data about the patient's daily activities, knowledge and beliefs, and an assessment of the patient's understanding of information and of his/her ability to carry out recommended tasks. The process of gathering baseline data, instructing the patient, and assessing understanding results in an individualization of the educational process which can then be called patient education. It must be noted also that patient education is a two way process, in which physician and patient often work together to develop treatment plans which the patient is able to follow, to enlist the support of friends and family, and to learn together the most effective means of managing illness events.

The instructional program funded by this contract, consists of six modular learning units which are designed to be spread throughout the three years of a primary care residency program. The modules teach increasingly difficult skills in patient education, so that the content of the later modules builds upon the lessons of the earlier modules.

The concept that the modules build and reinforce skills sequentially is basic to the design of the instructional program. Module One begins with communication skills because these skills lay the foundation for all other tasks on patient education. In Module Two, the assessment of patient beliefs and understanding is introduced, using open-ended questioning as discussed in Module One. Module Three combines the skills learned in the previous modules in the development of short-term individualized plans for patients, and Module Four adapts the plans learned in Module Three to the case of long term behavior changes. Module Five, Long Term Strategies: The special requirements of chronic illness, reinforces the discussion in Module Two of the patient's perception of illness and applies these ideas to the problems faced in the patient's adaptation to long term illness. The sequence of modules ends with incorporating patient education in practice in Module Six. The activities in this module apply all previously taught skills.

Module One: Communication and Basic Patient Education Skills, focuses on the physician's ability to effectively and efficiently present information to the patient. By the end of Module One, the resident should be able to use open-ended questions throughout the medical visit, use terminology and concepts familiar to the patient, explain the regimen in terms of specific behaviors, assess the patient's understanding, summarize conclusions and instruction at the end of the visit, and provide the patient with written instructions.

Module Two: Psychosocial Factors in Patient Education: How Patients Think About Illness presents the patient's perspective on illness and develops a framework within which the resident can assess this perspective. By the end of Module Two, the resident should be able to interview patients in a manner which facilitates reporting of symptoms. S/he should also be able to assess the patient's beliefs about the meaning of symptoms, the actions which the patient has taken to verify the etiology of symptoms or to relieve symptoms, and s/he should be able to prepare patients for the probable symptoms and sensations of the illness experience.

Module Three: Short-Term Strategies for Patient Education: The Need for Detail presents specific strategies for developing educational plans for short-term or acute illness problems. By the end of Module Three, the resident should be able to assess the patient's daily schedule in order to individualize the treatment plan and justify the regimen to the patient. S/he should be able to seek reactions of the patient about the feasibility of the recommended plan and ask the patient to explain the regimen, demonstrate self care skills, or explain methods of prevention.

Module Four: Patient Education Strategies for Health Promotion builds on the primary care physician's opportunity to identify potential activities for prevention and to work with the patient over time to change her/his behavior. Module Four addresses the special issues in the physician's role in health promotion, assessing patient's priorities for change, finding the appropriate times for discussing health promotion topics with patients and using specific individual and community strategies to encourage long-term behavior change. By the end of Module Four, the resident should demonstrate the ability to assess the patient's priorities for change, to introduce health promotion topics during patient visits in which other behavior changes are not indicated, and to respond to patient interest in health promotion with specific suggestions. S/he should also be able to assist the patient in choosing community referral resources for behavior change.

Module Five: Long-Term Strategies in Patient Education: The Special Requirements of Chronic Disease, builds on the skills taught in the previous modules in order to teach the resident to develop long-term patient education plans. The resident who completes the activities in Module Five should be able to establish a shared understanding with the patient about her/his diagnosis, explain the physiologic measures that are used to assess progress to the patient and engage her/him in an active role in carrying out the regimen. The resident should be able to assess the influence of various factors in the patient's life that affect her/his ability to adjust to a long-term condition, and provide the patient with an opportunity to talk about her/his attitudes, fears and adaptation to the demands and limitations of chronic illness.

Module Six: Incorporating Patient Education in Practice assists the resident in making decisions about incorporating patient education into practice. By the end of Module Six, the resident should be able to recognize her/his own abilities and limitations in educating patients and be able to work closely with other health care providers. S/he should also be able to evaluate commercially available patient education resources such as films and pamphlets and to develop patient education handouts and protocols. Finally, the resident should be able to assess the patient education needs of a practice.

INSTRUCTIONAL METHODS

Instructional methods used in each module to attain a set of behavioral objectives are: seminars, individual activities and specific recommendations to faculty for modeling patient education skills in the clinical setting. Each module is also accompanied by a discussion of the objectives which includes a brief review of relevant literature.

Direct observation of the resident's clinical skills and individualized instruction based on this observation is included in Modules One, Three and Four. Each observation and feedback activity focuses on the objectives of the module. This instructional activity is the core of the program for it provides an opportunity for residents to practice newly acquired skills and to receive feedback about their performance. Specific examples of resident skills are recorded on the observation and feedback protocols at several different times. Therefore, these documents can serve as invaluable aids for monitoring resident progress.

Seminars

Seminars allow some formal presentation of ideas while also encouraging discussion between residents and faculty. The inclusion of formal and informal role plays and simulation activities within the seminar has the added advantage of providing residents with the opportunity to practice new skills in a nonthreatening setting, away form actual encounters with patients. The seminars introduce the main ideas of the module and then reinforce them through a group activity. Active involvement of the residents in discussion or practice is emphasized in each seminar. An example of this comes from the second seminar in Module One, "Patient Adherence to Medical Regimens," in which residents are asked to take sugar pills four times a day for seven days prior to the seminar. This experience provides residents with an understanding of pill taking that is used for a discussion of the problems patients face. Most residency programs have seminar series and thus will be able to insert the seminars of the instructional modules into ongoing series.

Individual Activities

To supplement the learning in the seminars, individual activities are included for all modules. The aim of the individual activity is to provide the resident with a structured opportunity to try out the strategies suggested in the seminar and receive feedback on them. Most of the individual activities can be carried out in the clinical setting to encourage the residents to apply the lessons of the classroom to their daily activities with patients.

Observation of clinical encounters with feedback are used as individual activities in Modules One, Three and Four. The observation and feedback activities enable the residents to practice advocated behaviors and receive immediate feedback from faculty. It is an opportunity for individualized instruction, for it can be adapted to the needs of each resident. This process adds only feedback time to the resident's schedule. Many residencies incorporate in-the-room observations or videotape review in their programs; the use of this technique for instructing residents in patient education skills can be adopted simply by following the observation protocol.

The observations of clinical encounters were well accepted by the residents as they appreciated the opportunity to be observed at their normal pace of clinical activity. Feedback from observers was normally reserved until the conclusion of the clinic session, to minimize disruption. The residents remarked on the usefulness of specific suggestions for improving their skills.

Role of the Clinical Faculty

Because much of the learning in postgraduate medical education takes place through "hands-on" activity guided by individual instruction from an attending physician, clinical faculty are involved as instructors in patient education. A handbook, "Role of the Clinical Faculty," illustrates to them how they model good patient education skills to the residents, and provides the clinical faculty with specific methods for including instruction about patient education into their supervision of residents. This document is designed to help faculty translate the "art of medicine" into skills which they could teach to residents. The "Role of the Clinical Faculty" includes specific suggestions for instruction to reinforce each objective from each module.

Discussion of the Objectives

Although readings would appear to be a method of choice in post graduate education, previous experience of the project staff indicated that residents prefer not to spend time reading non-medical articles. Required readings are therefore kept short, and supplemented with suggested readings for interested learners. A specially prepared discussion of the objectives of each module provides a short reading for both faculty and residents. In order to demonstrate the scientific roots of patient education and to make the material accessible to a wide variety of health professionals, the "Discussion of the Objectives" of each module includes a justification of objectives supported by references from the social science and medical literature.

FIELD TESTING AND REVISIONS OF INSTRUCTIONAL MODULES

The instructional modules were field tested with 25 second and third year family practice residents and their faculty at the Madison residency of the Department of Family Medicine and Practice, University of Wisconsin. These residents see patients at three Family Practice Model Clinics within the Madison area. The division of residents into three clinical groups often allowed the comparison of different ways of presenting instructional materials in the field test. Seminars were scheduled independently, as part of the Behavioral Science series, at clinic and team meetings, and as part of other regularly scheduled educational conferences. It was found that residents preferred the seminars to be integrated into their regularly scheduled conference series, either Behavioral Science or community conferences, rather than scheduled as special events. Individual activities were scheduled with each resident individually, based on her/his time in clinic.

This contract funded a development of instructional modules, not an evaluation study. For this reason, rigorous evaluation was neither desirable nor necessary. However, the field test did include an informal evaluation of the acceptability and success of each seminar and activity as well as an assessment of how these activities could best be integrated into the residency curriculum. The instructional activities in the modules were revised both during the field test and in the period following the field test. During the field test, seminars were often presented two or three times, for second and third year residents separately, or at each model clinic. This provided the opportunity for revision of the seminars during their presentation, resulting in a better product after several presentations. Individual activities were also revised as the project staff gained experience using them with residents. As the modules were revised, seminar outlines and individual activities were formalized to include a discussion of preparations for the instructor and the resident. The seminars and activities were written so that they could be carried out by physicians, nurse educators, counselors, pharmacists, social workers, health educators or other health or behavioral science professionals with an interest in patient education. Preparations and seminar outlines were described in as much detail as possible.

A major period of revision followed the formal field test period. The total instructional program was reviewed, and objectives were again refined, and in some cases reassigned to modules where they were more appropriate. The sequence of the modules was also changed, as staff realized that the concepts taught in the chronic illness modules were more complex than those taught in the prevention module. A focus on "Wellness" within the prevention module was eliminated, when it became evident that this introduced a new conceptual area without added specific new skills to be taught.

UNDERLYING EDUCATIONAL PRINCIPLES OF INSTRUCTIONAL MODULES

How Residents Learn

Throughout the development and field testing and revision of the instructional modules to teach residents about patient education skills, the project staff made a conscious effort to apply the following educational principles:

1. The effectiveness of an educational activity is directly related to the residents' perceived need for the skills it teaches. Thus activities which deal with obvious problems, such as the patient who doesn't follow instructions are more valuable to the resident than more abstract activities or presentations.

2. An educational activity will be more effective in teaching skills if it is adapted to the specific needs of each learner. Individual activities, such as the observation and feedback activity, allow the resident to proceed at her/his own pace, and to set her/his agenda if desired. Individual activities are also advantageous in residency training because they can be conveniently scheduled at the best times for the resident.

3. Learning will be increased if the resident has an opportunity to see a demonstration of the desired skills. This principle is embodied in the medical adage "See one, do one, teach one," but is usually thought to apply only to psychomotor skills, rather than cognitive or affective skills. The involvement of clinical faculty in teaching patient education skills is based on the value of the role model to the resident.

4. The learner should have an opportunity to practice new skills in a similar or identical situation to that in which they normally will be used. Practice increases the learners comfort with a new technique and may afford the opportunity for feedback from peers or instructors.

This principle led to the inclusion of role plays in many of the seminars in the modules; this allowed practice of new techniques in a non-threatening setting.

5. Learning is more likely to occur if the learner has the opportunity to get feedback about new skills. Interchange between learner and instructor allows the immediate refinement of skills. Good performance can be reinforced, and suggestions for change made where problems exist. Without feedback, the learner does not know if s/he is doing a new skill correctly, and may abandon it because of uncertainty. All of the modules provide the residents with opportunities for feedback. Feedback, if designed to correct a problem, should include specific suggestions for improvement. This allows the resident to make informed changes in her/his behavior.

6. Residents are more likely to retain and utilize skills if s/he has an opportunity to practice those skills more than once. Repetition is certainly an important aspect of learning. The instructional modules often include repetition of objectives in several activities, or reinforcement in later modules to provide the residents with the opportunity to practice a skill in several different situations.

7. Theory must be linked directly to specific implications for practice. Theories about human behavior provide a basis for generalizations about how people act. They are more easily taught to the learner if s/he can see concrete examples of how these theories apply to her/his daily experiences, and how they help explain the human behavior s/he observes.

8. Traditional teaching methods such as lectures or reading are less effective in teaching patient education skills than those which

actively involve the learner in testing new ideas and skills through discussion and participation. Patient education skills, like basic skills in physical examination, need to be practiced before they are learned. Lectures and reading may provide background information, but skills are refined through the learner's discussion of her/his own experiences in case presentations or group discussions, and through opportunities for practice in real and simulated settings.

RECOMMENDATIONS FOR IMPLEMENTATION

Integration with the Existing Residency Curriculum

The experiences gained from field testing these instructional modules to teach patient education skills has led us to recommend that the modules should be integrated into the existing residency curriculum, rather than presented as separate educational experiences. Integration emphasizes the role of patient education as part of the entire clinical encounter. Integration has the advantages of increasing acceptance by residents of the instructional activities and involving clinical faculty in the teaching of these activities. The observation and feedback activity in particular provides opportunities to identify and reinforce patient education skills the resident uses in daily clinical encounters.

Time Frame for Implementation

The instructional modules are designed so that they can be implemented in a variety of ways, to suit the differing needs of residency programs. In a program where residents are separated into first, second or third years of residency for some of their educational experiences (behavioral science seminars, for example), the modules can be spread throughout the three year training period. Module One can begin after the initial adjustment period of first year residents during the first three months of the year. Modules One and Two, dealing with communication skills and psychosocial factors in patient education are ideal for first year residents, for they provide a foundation in patient education yet are not dependent on the residents discussion of actual outpatient experiences. Modules Three, Four and Five do draw on the residents' experiences and assist them in developing strategies for educating patients. These modules are best suited to the second year of residency and the beginning of the third year. Module Six, which addresses incorporating patient education into practice is most appropriate for residents in their third year, although many of the activities can be adapted for residents interested in improving patient education in the model clinic.

The program of instructional modules are designed so that they can be adapted to varying time needs of residencies. Many of the seminars include one or two hour options, and activities can be carried out in different ways based on the available faculty time.

Instructors will find that when first, second and third year residents are combined for patient education seminars and activities, residents begin to teach each other. This can be used to great advantage, for first year residents are eager to model themselves upon their more experienced colleagues.

Staff

The activities and seminars in each module include specific instructions for the instructor, so that previous in-depth knowledge of the area is not required. The modules are designed in this manner so that they may be used by a wide range of professionals. Within a particular residency program, use of the therapeutic educational modules could be coordinated by:

a physician
a social worker
a counselor
a nurse educator
a psychologist
a pharmacist
or other professional
or by interested residents

The person who assumes responsibility for the instructional modules should have some training in the behavioral sciences, a strong interest in patient education and a sensitivity to the needs and interests of patients as well as physicians.

CONCLUSION

In the development and testing of these instructional modules, it became evident that patient education in primary care needs to be broadly defined to include the full range of educational activities which contribute to the patient's ability to make informed decisions about her/his health and health related behaviors. Patient education thus includes more than educational activities related to planning for future care and increasing patient compliance; it includes assessing patients' needs and concerns, informing patients about sensations and rationales for procedures and about diagnoses, and negotiating with patients to develop acceptable and suitable plans for care. Although patient education is built upon the physician's ability to communicate clearly and specifically, it is a two way process, involving contributions of both patient and physician.

REFERENCES

1. Bartlett, E.E. Physician Health Education Competencies. Mimeo. Johns Hopkins School of Public Health, Baltimore, April, 1979.

2. Green, L.W. Educational strategies to improve compliance with therapeutic and preventive regimens: The recent evidence. Compliance in Health Care, Johns Hopkins University Press, Baltimore, 1979.

3. Green, L.W., et al. Health Education Planning: A Diagnostic Approach. Mayfield, Pub., Palo Alto, CA 1980.

4. Leventhal, H. The consequences of depersonalization during illness and treatment. In Humanizing Health Care, edited by J. Howard and A. Strauss. Wiley, New York.

5. Leventhal, H., Meyer, D., and Nerenz, D. The common sense representation of illness danger. In Medical Psychology, edited by S. Rachman. Pergamon Press, New York, 1980, Vol. II.

6. Ley, P. Psychological studies of doctor-patient communication. In Contributions to Medical Psychology, edited by S. Rachman. Pergamon Press, New York, 1977, Vol. I, pp. 9-42.

7. Svarstad, B. Patient Compliance with Drug Regimens: An Analysis of Communication Techniques. Hamilton, Illinois: Drug Intelligence Publications, Inc., 1981.

INSTRUCTIONAL MODULES TO TEACH PRIMARY CARE RESIDENTS TO EDUCATE PATIENTS

FINAL REPORT

D.H.H.S. Contract No. 232-79-0026

Project Director
Marion Field Fass, Sc.D.
University of Wisconsin
Department of Family Medicine and Practice

HRP-0903682

INSTRUCTIONAL MODULES TO TEACH PRIMARY CARE RESIDENTS TO EDUCATE PATIENTS

Final Report
Covers Period of Performance
During
March 6, 1979 - March 5, 1981

Contract No. HRA 232-79-0026

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PREFACE

The work described in this document was funded by the Health Resources Administration, Division of Medicine, under Contract No. HRA 232-79-0026 to the University of Wisconsin, Department of Family Medicine and Practice, Madison, Wisconsin, 53715. The project is titled, "Instructional Modules to Teach Primary Care Residents to Educate Patients." The project director was Marion Field Fass, Sc.D., Assistant Professor, and Coordinator of Patient Education, Department of Family Medicine and Practice. Linda M. Vahldieck, M.A., M.S., Project Specialist in the Department of Family Medicine and Practice had primary responsibility for project administration. Daniel L. Meyer, Ph.D., Project Specialist in the Department of Family Medicine and Practice had primary responsibility for providing theoretical and empirical justification of the curriculum content. The final instructional modules described here were jointly developed, field tested and written by Dr. Fass, Ms. Vahldieck and Dr. Meyer. G. Thomas Pfaehler, M.D. participated in the development and field testing of Module 5. John H. Renner, M.D., and Bruce F. Currie, Ph.D. were staff consultants. Randy Hackbarth, M.S. conducted the hypertension and weight loss chart reviews during field testing and wrote the instruction pamphlets for both chart reviews. Typing was done by Linda Kosbau and Joni Dean, and final editing by Mary Nell Currie and Linda M. Vahldieck, M.A., M.S.

An Advisory Committee met three times to review and discuss the progress of the project. Members were Janet Aradine, patient, St. Mary's Family Practice Clinic, Madison, Wisconsin; Lynn Buhmann, R.N., M.S., Clinical Nurse Specialist, Wausau Family Practice Center, Univerisity of Wisconsin, Department of Family Medicine and Practice; Eric Heaney, M.D., Resident, University of Wisconsin, Department of Family Medicine and Practice; Lynn Phelps, M.D., Associate Professor and Director of the Northeast Family Practice Clinic, University of Wisconsin, Department of Family Medicine and Practice; John H. Renner, M.D., Director of the Family Practice Residency, St. Mary's Hospital and Clinical Professor at the University of Missouri, Kansas City, Missouri; Richard Shropshire, M.D., Practicing Family Physician, Monona Grove Clinic, Monona, Wisconsin; William Stewart, M.D., Professor and Chairman, University of Florida, Department of Community Health and Family Medicine; Bonnie Svarstad, Ph.D., Associate Professor, University of Wisconsin, School of Pharmacy; and Margaret Wilson, Ph.D., Project Officer, Health Resources Administration, Division of Medicine, Hyattsville, Maryland.

Many people helped in the development of the instructional modules by sharing their ideas and projects. The listing of physician health education competencies developed by Edward Bartlett, Dr. P.H., of the University of Alabama, Department of Family Practice, guided our development of objectives. The physician observation form designed by Mary Ann Kluemper, M.P.H., of the University of Nebraska, Department of Family Medicine, provided a model for the development of our observation protocol. Patricia Murphy, R.N., M.S., of Rutgers University, College of Nursing, kindly let us adapt her simulation game, Terminex, to the conditions of chronic illness discussed in Module 5. Gary Arsham, M.D., Ph.D., of the Pacific Ohio College of Medicine, and Donna Talkington Falvo, Ph.D., R.N., of Southern Illinois University, Department of Family Medicine, all read the first draft of the modules and provided us with useful comments and insights.

We would like to thank the residents and the faculty of the University of Wisconsin, Department of Family Medicine and Practice. The residents, who participated in the field testing, provided invaluable assistance through their evaluation of the content and format of the activities in the modules. William E. Scheckler, M.D., Chairman, and the faculty, provided a model of the art of clinical medicine which helped us to identify the patient education skills that are taught in the modules.

The advice and assistance of Dr. Margaret Wilson, the project officer from the Health Resources Administration was of great value to this project.

ABSTRACT

The Instructional Modules to Teach Primary Care Residents to Educate Patients were developed and field-tested at the University of Wisconsin, Department of Family Medicine and Practice's Madison residency with funding provided by Health Resources Administration Contract No. HRA 232-79-0026. This instructional program consists of six modules which address: 1) communication and basic patient education skills, 2) how patients think about illness, 3) patient education strategies for short-term planning, 4) patient education strategies for health promotion, 5) patient education strategies for long-term planning, and 6) methods of incorporating patient education into practice. Each module consists of instructions for seminars, individualized resident activities, and the role of clinical faculty in teaching patient education in a clinic setting as well as a bibliography and a brief review of relevant literature. All six modules were revised based on informal evaluation of residents, faculty and staff who participated in the field testing. Recommendations are made for implementing the modules into existing primary care residency curricula.

Instructional Modules to Teach Primary Care Residents to Educate Patients

PURPOSE OF THE CONTRACT

The need for an instructional program in patient education

The purpose of this project, funded by the Health Resources Administration, Contract No. 232-79-0026, was to develop an instructional program in patient education skills for primary care medical residencies. This instructional program is designed to fill a gap in medical training, that is, to systematically educate primary care physicians to better communicate with their patients about health, disease, and treatment.

Patient education is an activity that runs throughout the entire medical encounter. While patient education certainly includes the clear provision of information and instruction in necessary skills, it also includes accurate gathering of data about the patient's daily activities, knowledge and beliefs, and an assessment of the patient's understanding of information and of his/her ability to carry out recommended tasks. The process of gathering baseline data, instructing the patient, and assessing understanding results in an individualization of the educational process which can then be called patient education. It must be noted, also, that patient education is a two way process, in which physician and patient often work together to develop regimens which the patient is able to follow, to enlist the support of friends and family, or to learn together the most effective means of managing illness events.

The value of effective patient education in improving medical care has been suggested by recent research in a number of related areas. Studies of patient adherence to medical regimens demonstrate that patients often receive inadequate or confusing instructions from their physicians (1) and may misinterpret what their physicians do explain.(2) Educational programs which emphasize adapting the regimen to the patient's daily schedule(3) and clarifying information about the regimen(4) result in better adherence to regimens for hypertension. Medical care which emphasizes an active role for the patient has been shown to be related to better levels of blood pressure control.(5)

Studies of routine medical practice, however, suggest that physicians in primary care do not spend a great deal of time educating patients. Noren(6) reviewing national ambulatory care data found that internists provide instruction and health education as a significant part of treatment in 17.8 per cent of visits and family-general practitioners in 12.4 per cent of visits. Platt and McMath(7), reviewing the skills of internal medicine residents, found differences in the residents' ability to collect data relevant to the patient's life and current concerns, their ability to generate usable data from an interview, and found that many interviews had low therapeutic content.

Given the evidence which suggests the importance of patient education to the outcome of medical care and the suggestion that education is not adequately attended to in the medical encounter, one would expect to find an abundance of educational experiences for medical students and residents which are designed to develop skills in patient education. In the last several years, instruction in patient education skills has received increased emphasis in medical training programs. A survey of health education programs in medical education listed 99 programs in 1980, compared to 43 in 1979.(8) Bartlett notes "the emphasis on making the patient education instruction more relevant to clinical problems by using clinical observation of students and residents, videotaping, and provision of consultation and referral services for patient education (1980)."

Many medical schools and residencies, however, do not include formal instruction in patient education skills. This may be due to lack of interest, inadequate staff, or inadequate time to develop a new instructional program. Prior to the development of the instructional modules sponsored by this contract, no guidelines or teaching manuals for teaching patient education were available in the United States. The development of a flexible instructional program in patient education would be of benefit to training programs which lack the resources to develop their own instructional materials, yet are interested in producing graduates with skills in communication and patient education.

Focus on primary care residencies

Within medical training, an instructional program to teach patient education skills is most appropriate for postgraduate medical education, particularly the primary care residency. At this time, physicians in training have mastered the basic sciences, have progressed through the rigors of hospital training, and are concentrating on applying medical skills in the outpatient setting. While basic communication and patient education skills are important for the physician in the inpatient setting, they assume an increased importance in outpatient medicine, where the patient, using the knowledge and skills acquired from the physician, is responsible for her/his own care.

In primary care postgraduate training programs, the trainee's direct patient contact is greatly increased over that in medical school, as is the continuity of care s/he is able to provide to patients. In this situation, the need for good patient education skills becomes evident to the resident as well as her/his teachers. While a case can be made for teaching patient education skills to medical students, because of their greater receptivity before their clinical styles are established, it appears that education in patient education skills would be more effective in a setting where the skills were practiced daily, and in which feedback on success from patients and instructors is available to the trainee. This is the case in primary care residency programs.

Within primary care residency programs in the specialties of family medicine, pediatrics and internal medicine, family medicine stands out as having made a commitment to instructing residents in patient education skills. The Society of Teachers of Family Medicine, together with the National High Blood Pressure Education Program, recently participated in a National Task Force on Training Family Physicians in Patient Education. The report of this task force, Patient Education, A Handbook for Teachers,(9) has been made available to all family practice training programs through the Society of Teachers of Family Medicine. The need for training in patient education and community health education is specifically noted in the Residency Assessment Program Criteria(10) of the American Academy of Family Physicians, the American Board of Family Practice, the Society of Teachers of Family Medicine and the Family Health Foundation of America.

The instructional modules funded under this contract have been developed at the University of Wisconsin, Department of Family Medicine and Practice. Wisconsin stands out among other residencies as a leader in patient education in family medicine. The Department's first chairman, Dr. John Renner, has had a long term commitment to patient education, and has served on the National Task Force on Training Family Physicians in Patient Education. Dr. Renner also initiated the national conference series, Patient Education in the Primary Care Setting and chaired the first conference in 1977. The Department has had a patient educator on the staff since 1973, and a faculty member with specific responsibilities for patient education training since 1977.

Overview of the Instructional Modules

The instructional program, funded by this contract, consists of six modular learning units. The modules teach increasingly difficult skills in patient education, so that the content of the later modules builds upon the lessons of the earlier modules. The modules, although field tested in a twelve month period, are designed to be spread throughout the three years of a primary care residency program.

Module One; Communication and Basic Patient Education Skills, focuses on the physician's ability to effectively and efficiently present information to the patient. By the end of the instructional activities in the module, the resident should be able to use open ended questions throughout the medical visit, use terminology and concepts familiar to the patient, explain the regimen in terms of specific behaviors, assess the patient's understanding, summarize conclusions and instruction at the end of the visit, and provide the patient with written instructions.

Module Two; Psychosocial Factors in Patient Education: How Patients Think About Illness presents the patient's perspective on illness and develops a framework within which the resident can assess this perspective. By the end of Module Two, the resident should be able to interview patients in a manner which facilitates reporting of symptoms. S/he should also be able to assess the patient's beliefs about the meaning of symptoms, the actions which the patient has taken to verify the etiology of symptoms or to relieve symptoms, and s/he should be able to prepare patients for the probable symptoms and sensations of the illness experience.

Module Three, Short-Term Strategies for Patient Education: The

Need for Detail presents specific strategies for developing educational plans for short term or acute illness problems. By the end of Module Three, the resident will be able to assess the patient's daily schedule in order to individualize the treatment plan and justify the regimen to the patient. S/he will be able to seek reactions of the patient about the feasibility of the recommended plan and ask the patient to explain the regimen, demonstrate self care skills, or explain methods of prevention.

Module Four; Patient Education Strategies for Health Promotion builds on the primary care physician's opportunity to identify potential activities for prevention and to work with the patient over time to change her/his behavior. Module Four addresses the special issues in the physician's role in health promotion, assessing patient's priorities for change, finding the appropriate times for discussing health promotion topics with patients and using specific individual and community strategies to encourage long-term behavior change. By the end of Module Four, the resident will demonstrate the ability to assess the patient's priorities for change, to introduce health promotion topics during patient visits in which other behavior changes are not indicated, and to respond to patient interest in health promotion with specific suggestions. S/he will also be able to assist the patient in choosing community referral resources for behavior change.

Module Five, Long-Term Strategies in Patient Education: The Special Requirements of Chronic Disease, builds on the skills taught in the previous modules in order to teach the resident to develop long-term patient education plans. The resident who completes the activities in Module Five should be able to establish a shared understanding with the patient about her/his diagnosis, explain the physiologic measures that are used to assess progress to the patient and engage her/him in an active role in carrying out the regimen. The resident will be able to assess the influence of various factors in the patient's life that affect her/his ability to adjust to a long-term condition, and will provide the patient with an opportunity to talk about her/his attitudes and fears and about her/his adaptation to the demands and limitations of her/his chronic illness.

Module Six, Incorporating Patient Education in Practice, assists the resident in making decisions about how patient education will be incorporated in her/his practice and provides her/him with tools for assessing patient education needs in practice. By the end of Module Six, the resident should be able to recognize her/his own abilities and limitations in educating patients and be able to work closely with other health care providers. S/he will also be able to evaluate commercially available patient education resources such as films and pamphlets and be able to develop patient education handouts and protocols. Finally, the resident will be able to assess the patient education needs of her/his practice.

Each module in the instructional program is built around a set of behavioral objectives. In order to attain these objectives, residents participate in two seminars and at least one individual activity. In addition each module includes suggestions for teaching patient education skills through the resident's medical encounters, so that attending physicians and nurse practitioners can reinforce the skills taught in the seminars and activities. Each module is also accompanied by a discussion of the objectives which includes a brief review of relevant literature.

Direct observation of the resident's clinical skills and individualized instruction based on this observation is included in Modules One, Three and Four. Each observation and feedback activity focuses on the objectives of the module. This instructional activity is the core of the program for it provides an opportunity for residents to practice newly acquired skills and to receive feedback about their performance. Specific examples of resident skills are recorded on the observation and feedback protocols at several different times. Therefore, these documents can serve as invaluable aids for monitoring resident progress.

DESCRIPTION OF TASKS REQUIRED IN THE DEVELOPMENT OF THE INSTRUCTIONAL MODULES

Preliminary tasks

Initial preparation for the development of the instructional modules was described in the funding proposal. A basic outline of an educational program was developed and support within the Department of Family Medicine was assessed. A timetable for the completion of major tasks of the project was established. Potential members for an Advisory Committee were identified.

Planning of the Instructional Program

In order to develop an instructional program, one must identify the material to be taught, survey existing resources, assess the needs of the residency programs in which the instructional program will be used, and, based on this information, design a set of educational objectives.

Several resources aided in the identification of the content of the instructional modules. Golden(11) developed a list of educational tasks in primary care practice, based on the results of a task analysis of practicing physicians and nurses. These tasks, rated by amount of cognitive and affective skill needed for performance, guided the development and sequencing of content in the instructional program. Also helpful in developing content were Bartlett's(12) listing of physician health education competencies. Developed through a Delphi survey of health professionals and consumers, these competencies "are intended as the basis for the development of competency-based curricula to train medical students, residents and practicing physicians in primary care." Bartlett's listing of competencies were also used later as the basis for many of the educational objectives of the modules.

A review of the literature on health and patient education, physician-patient interaction and patient compliance added depth to the content for the instructional modules. Particularly important were works by Green(13)(14), Leventhal(15)(16), Ley(17) and Svarstad(1). Green's work on patient education(13) and health education planning(14) provided a broad definition of patient education which encompassed an understanding of individual, environmental and social factors in the development of educational strategies. Leventhal's discussions of the patient's perception of illness(15)(16)provided a theoretical orientation which shaped Module Two and was to run throughout the instructional modules. Ley's studies of physician-patient communication(17) and Svarstad's observations of physician-patient encounters(1) supplied empirical data on which to base instruction in patient education skills.

A search for materials available to teach patient education skills to medical students or primary care residents failed to yield detailed materials. The Report of the Task Force on Training Family Physicians in Patient Education(9) included a brief listing of educational activities, as did the handbook which accompanies the National Medical Audiovisual Library's film, "Beyond Compliance (1978)". General program descriptions were available from the conference proceedings of Patient Education in the Primary Care Setting(18) and from the Physician's Health Education Newsletter. Specific assistance did come, however from Marianne Klumper, MPH, of the University of Nebraska, who shared an observation protocol which she had used with family practice residents(19). This protocol, revised, and combined with the feedback method developed by

Brockway and Sternburg(20) in the Department of Family Medicine at the University of Wisconsin-Madison, was to become a major component of the instructional modules.

An assessment of the need for instruction in patient education within the Department of Family Medicine at the University of Wisconsin produced different responses from different groups. Residents wanted information on patient handouts, films, and tips for practice management. Faculty family physicians wanted to improve the residents' skills in interacting with patients, but they were not sure that was patient education. Nurses wanted residents to be more sensitive to patients' needs and to learn to work better with nurses as team members. Behavioral scientists wanted residents to gain more practical skills in communicating with patients, assessing their needs and assisting them to change behaviors. Although no one group specifically asked for instruction in skills in patient education, it appeared that this was because of a lack of agreement on the meaning of the term patient education rather than because the need was not felt. The needs assessment when combined with the findings of the task analyses and literature review resulted in defining a broad area of content for the instructional program described below.

Designing Instructional Program

The content of the instructional program fell neatly into modular units. Modules One and Two would deal with the basic skills of communicating clearly and assessing patient needs, Modules Three, Four and Five would build strategies for patient education based on these skills, and Module Six would address the third year resident's interest in implementing patient education in practice. An early decision to base each module on one disease or health problem was abandoned due to the realization that there are many different problems seen in family medicine, and that few problems are seen frequently enough to merit the focus of an entire module. The skills taught in Modules One and Two apply to every medical encounter. Module Three, short term strategies, draws examples from a variety of medical conditions. Module Four, strategies for health promotion, draws on the examples of smoking and overweight, while Module Five, long term strategies for patient education, uses hypertension as one example of a chronic illness, but leaves the module open to other examples offered by the residents. Module Six does not have an illness theme.

The concept that the modules build and reinforce skills sequentially is basic to the design of the instructional program. Module One begins with communication skills because these skills lay the foundation for all other tasks on patient education. In Module Two, the assessment of patient beliefs and understanding is introduced, using open ended questioning as discussed in Module One. Module Three combines the skills learned in the previous modules in the development of short-term individualized plans for patients, and Modules Four and Five adapt the plans learned in Module Three to the case of long term behavior changes. Module Five, Long term strategies: The special requirements of chronic illness, reinforces the discussion in Module Two of the patient's perception of illness and applies these ideas to the problems faced in the patient's adaptation to long term illness. The sequence of modules ends with incorporating patient education in practice in Module Six. The activities in this module apply all previously taught skills.

The determination of instructional methods to be used in the modules was an important task in the program development. The full range of educational methods commonly used in medical training programs were considered. These included:

- -case presentations, at seminars or rounds
- -team meetings
- -clinical observation and feedback in person, by audiotape, by videotape
- -reading
- -learning by doing - the "hands on" experience
- -individualized instruction by attending physicians
- -role modeling by health educators, nurse practitioners, pharmacists, etc.
- -seminars
- -role plays and simulations
- -lectures
- -chart reviews and feedback

An effort was made to select those methods which maximized the educational impact without using too much resident time. It was also decided to try to use a variety of educational methods, to try to suit the needs of different types of learners.

Several basic instructional methods were chosen. The seminar was chosen because it allows some formal presentation of ideas but also encourages discussion between residents and faculty. The inclusion of formal and informal role plays and simulation activities within the seminar has the added advantage of providing residents with the opportunity to practice new skills in a nonthreatening setting, away from actual encounters with patients. Most residency programs have seminar series and thus would be easily able to adopt these parts of the instructional modules.

The observation of clinical encounters with feedback was also chosen as a basic instructional method. The observation and feedback activity enables the resident to practice advocated behaviors and receive immediate feedback from faculty. It is an opportunity for individualized instruction, for it can be adapted to the needs of each resident. Although the process of observing residents does use a great deal of faculty time, it adds only feedback time to the resident's schedule. Many residencies incorporate in-the-room observations or videotape review in their programs: the use of this technique for instructing residents in patient education skills can be adopted simply by following a protocol for reviewing patient education.

Although readings would appear to be a method of choice in post graduate medical education, previous experience of the project staff indicated that residents preferred not to spend time reading non-medical articles. It was therefore decided to keep required readings short, and to supplement them with suggested readings for interested learners. A specially prepared discussion of the objectives of each module provides a short reading for both faculty and residents.

Because much of the learning in postgraduate medical education takes place through "hands-on" activity guided by individual instruction from an attending physician, it was decided to involve clinical faculty as instructors in patient education. A handbook for clinical faculty illustrated to them how they model good patient education skills to the residents, and provided the clinical faculty with specific methods for including instruction about patient education into their supervision of residents. This document was designed to help faculty translate the "art of medicine" into skills which they could teach to residents.

In order to integrate module objectives, content and instructional methods and to develop time estimates for each module, project staff developed a grid. This grid listed educational methods and modules. Then, by reviewing each module's objectives, project staff were able to devise a range of educational activities for each module which would be able to be integrated into a total instructional program.

Development and Field Testing of Each Module

After the initial planning of the instructional program, individual modules were designed and field tested. The project schedule did not call for all modules to be developed simultaneously. Rather, Module One would be developed in May and field tested in June, Module Two would be developed in July and field tested in August, etc., rather than developing all the modules in one block of time and then field testing them. This integration had the advantage of allowing staff to use the lessons learned in field testing one module in the development of another. It had the disadvantage, however, of keeping the staff from revising each module until the whole program was completed. The extensive work to unify and revise the instructional program after the initial field testing of the modules resulted in the need to extend the contract period of work by six months.

The development of individual modules began with the refinement of objectives which had been assigned to each module when the total instructional program was divided into modules. Each objective was written to specify an observable resident behavior so that actual progress could be measured. The range of objectives for each module needed to be narrowed to make the goals of the module attainable.

From the objectives, the staff proceeded to develop detailed outlines for the two seminars of the module. The seminars were intended to introduce the main ideas of the module and then to reinforce them through a group activity. Active involvement of the residents in discussion or practice was emphasized in each seminar. An example of this comes from the second seminar in Module One, "Patient Adherence to Medical Regimens," in which residents are asked to take sugar pills four times a day for seven days prior to the seminar. This provides residents with a common experience of pill taking from which to discuss the problems patients face.

To supplement the learning in the seminars, individual activities were also developed for all modules. The aim of the individual activity was to provide the resident with a structured opportunity to try out the strategies suggested in the seminar and receive feedback on them. Most of the individual activities were designed to be carried out in the clinical setting, to encourage the residents to apply the lessons of the classroom to their daily activities with patients.

The instructional modules were field tested with 25 second and third year family practice residents and their faculty at the Madison residency of the Department of Family Medicine and Practice, University of Wisconsin. These residents see patients at three Family Practice Model Clinics within the Madison area. The division of residents into three clinical groups often allowed the comparison of different ways of presenting instructional materials in the field test.

The field test included an evaluation of the acceptability and success of each seminar and activity as well as an assessment of how these activities could best be integrated into the residency curriculum. Seminars were scheduled independently, as part of the Behavioral Science series, at clinic and team meetings, and as part of other regularly scheduled educational conferences. It was found that residents preferred the seminars to be integrated into their regularly scheduled conference series, either Behavioral Science or community conferences, rather than scheduled as special events. Individual activities were scheduled with each resident individually, based on her/his time in clinic. This generally worked well.

Revision of the Instructional Modules

Instructional activities were revised based on informal evaluations by residents, faculty and staff. Participation by residents in the activities of the modules often provided a powerful evaluation of acceptability and thus success of the activity. For example, three individual activities were included in the initial version of Module Two. Although these activities were initially designed to be self administered by the residents, it was discovered early that residents only completed the activity when reminded by on-site patient education instructors. In addition, discussion with the residents after doing the activities indicated that they were unable or unwilling to reflect on the subtle variations in patient perceptions or patient behavior which were identified by the activities, during the course of a busy clinic schedule. Based on resident response, individual activities were dropped from Module Two and replaced with the indepth discussion and reflection in the seminars.

The instructional activities in the modules were revised both during the field test and in the period following the field test. During the field test, seminars were often presented two or three times, for second and third year residents separately, or at each model clinic. This provided the opportunity for revision of the seminars during their presentation, resulting in a better product after several presentations. Individual activities were also revised as the project staff gained experience using them with residents. Project staff met weekly to review progress with the activities and to make necessary changes.

A major period of revision followed the formal field test period. The total instructional program was reviewed, and objectives were again refined, and in some cases reassigned to modules where they were more appropriate. The sequence of the modules was also changed, as staff realized that the concepts taught in the chronic illness modules were more complex than those taught in the prevention module. A focus on "Wellness" within the prevention module was eliminated, when it became evident that this introduced a new conceptual area without added specific new skills to be taught.

As the modules were revised, seminar outlines and individual activities were formalized to include a discussion of preparations for the instructor and the resident. The seminars and activities were written so that they could be carried out by physicians, nurse educators, counselors, pharmacists, social workers, health educators or other health or behavioral science professionals with an interest in patient education. Preparations and seminar outlines were described in as much detail as possible.

The formalization of the activity outlines reflected a formalization in the format of each module. In order to demonstrate the scientific roots of patient education and to make the material accessible to a wide variety of health professionals, a discussion of the objectives of each module was prepared. This discussion included a justification of the objectives supported by references from the social science and medical literature. The handbooks for clinical faculty were also revised, to include specific suggestions for instruction to reinforce each objective from each module.

DESCRIPTION OF METHODS, LOGICAL APPROACH AND ANALYTICAL PROCEDURES EMPLOYED

Background

This contract funded a development of instructional modules, not an evaluation study. For this reason, rigorous evaluation was neither desirable nor necessary. The methodological requirements of an evaluation study would interfere with the development of rapport and cooperation necessary for the acceptance of this educational innovation. In addition, variability between residency training programs ruled out the availability of a reasonable comparison group for analysis.

Methods used

The individual instructional modules were evaluated only by informal evaluation methods, including attendance at seminars, compliance with individual activities and frequent staff meetings to evaluate task progress and problems. The accuracy of counts of compliance with activities and attendance was compromised by the many legitimate excuses residents had, including rotations on the coronary care unit, or months spent at distant sites. Staff evaluation focused on group involvement in seminars, amount of discussion, and evidence of learning.

Several of the educational activities in the modules were potentially useful for evaluation, although they all have major methodological inadequacies. The instructional program included medical record reviews, a needs assessment questionnaire, and observations of clinical encounters before and after the instructional program. The use of these measures without a control or comparison group, makes it difficult to attribute any changes which might be demonstrated to the instructional program rather than to the effects of maturation.

The medical record review collected data from ten charts of each resident before and after the instructional program. The initial record review was used as data for an individual activity in Module One, but was eliminated from the design of Module Six and also eliminated when Module One was revised because feedback focused more on charting behavior than patient education. The criteria for the chart review, with the exception of the criterion relating to written instructions, did not relate directly to the final set of objectives for the instructional modules. Comparing observation forms with record reviews, it was found that the process of patient education was not accurately reflected in the medical record, invalidating this as a method of evaluation for the instructional program.

The needs assessment questionnaire which accompanies the National Medical Audiovisual Library film, "Beyond Compliance" was also used as a pretest measure to assist project staff in development of the modules. This questionnaire was also given to residents as a post test, but response was poor (only 12 of 25 residents filled it out). Responses seemed to indicate, however, that residents did not understand the educational terms in the questionnaire. Several residents evaluated their skills more poorly at post test than pretest. This can be attributed to better understanding of the terminology of the questionnaire at the post test. The observation form was used at the beginning and end of the instructional program with all of the residents. It was intended as an instructional aid, not an evaluation tool. This form addressed most but not all of the objectives of the instructional modules, but did not allow the collection of quantitative data. This problem compromises its usefulness for evaluation, although some comparisons are possible.

The total instructional program was also evaluated informally by the project staff and by residents, faculty and staff of the University of Wisconsin Department of Family Medicine and Practice. Acceptance of the instructional activities increased throughout the program, and it was easier for instructors to schedule activities with residents at the end of the program than at the beginning. Instructors also noted improvement in resident skills through the course of the program.

RESULTS ACHIEVED BY THE INDIVIDUAL INSTRUCTIONAL ACTIVITIES

The observations of clinical encounters were well accepted by the residents. The residents appreciated the opportunity to be observed at their normal pace of clinical activity. Feedback from observers was normally reserved until the conclusion of the clinic session, to minimize disruption. The residents remarked on the usefulness of specific suggestions for improving their skills.

The success of seminars appeared to be directly related to the amount of active involvement in the seminars. Residents responded to the opportunity to draw on their own personal experiences in trying to understand the behavior of patients.

Activities which related to the residents' own future practice were also well received. These activities taught practical skills in evaluating commercially prepared patient education materials, and in developing handouts. The activities, especially the Module Six seminar, "Evaluating Patient Education Films," encouraged the residents to be critical of commercial products if they did not meet the residents' objectives.

The faculty handbooks which accompanied each module were not universally read or used by the residency's clinical faculty. These needed to be distributed personally, and accompanied by faculty development discussion to maximize their utility.

Module Two, as originally field-tested, did not meet the educational needs of the residents. The module initially addressed all the factors which influence the physician-patient relationship. This orientation was far too broad, and made it difficult to specify behavioral interventions based on the factors discussed. Module Two was completely revised and field tested with a new group of second year residents. The module has been narrowed to discuss the influence of the patient's perception of illness on her/his behavior and includes specific behavioral interventions based on an understanding of the patient's perception.

OVERALL RESULTS

Informal Evaluation

By the conclusion of the contract, the contractor has developed, implemented and informally evaluated an instruction program consisting of six modular units designed to teach patient education skills to primary care residents. All of the instructional activities have been field tested in the University of Wisconsin's Madison residency program, and the majority have now been formally integrated into the residency curriculum. In addition, the affiliated residency programs in the University of Wisconsin Department of Family Practice have requested that the modules be implemented in their programs, and the modules are presently being implemented in the Eau Claire, Wisconsin residency. This latter program has provided experience in a smaller residency program where all three years are combined for seminars.

The observation protocol, the core of the instructional program has also been accepted as part of the residency curriculum. After a faculty development seminar, clinical faculty stated that the observation format assisted them to label and teach patient education skills which they considered the "art of medicine." The data from the observation has also been useful to residency faculty in the evaluation of resident progress.

Formal evaluation

The major task of this contract was the development of field-tested instructional modules. Results of comparisons of the observation data, record reviews and needs assessment questionnaires are not presented here because of the methodological problems discussed above. Proper evaluation would require a sample of several residencies using the instructional modules, and appropriate comparison groups. Further refinement of the data collection tools would also be suggested.

CONCLUSIONS AND RECOMMENDATIONS

Patient education in primary care

In the development and testing of these instructional modules, it became evident that patient education in primary care needs to be broadly defined to include the full range of educational activities which contribute to the patient's ability to make informed decisions about her/his health and health related behaviors. Patient education thus includes more than educational activities related to planning for future care and increasing patient compliance; it includes assessing patients' needs and concerns, informing patients about sensations and rationales for procedures and about diagnoses, and negotiating with patients to develop acceptable and suitable plans for care. Although patient education is built upon the physician's ability to communicate clearly and specifically, it is a two way process, involving contributions of both involved parties.

How residents learn

Through the development and field testing of the instructional modules to teach residents about patient education skills, the project staff made a conscious effort to apply the following educational principles:

1) The effectiveness of an educational activity is directly related to the residents' perceived need for the skills it teaches. Thus activities which deal with obvious problems, such as the patient who doesn't follow instructions are more valuable to the resident than more abstract activities or presentations.

2) An educational activity will be more effective in teaching skills if it is adapted to the specific needs of each learner. Individual activities, such as the observation and feedback activity, allow the resident to proceed at her/his own pace, and to set her/his agenda if desired. Individual activities are also advantageous in residency training because they can be conveniently scheduled at the best times for the resident.

3) Learning will be increased if the resident has an opportunity to see a demonstration of the desired skills. This principle is embodied in the medical adage "See one, do one, teach one," but is usually thought to apply only to psychomotor skills, rather than cognitive or affective skills. The involvement of clinical faculty in teaching patient education skills is based on the value of the role model to the resident.

4) The learner should have an opportunity to practice new skills in a similar or identical situation to that in which they normally will be used. Practice increases the learners comfort with a new technique and may afford the opportunity for feedback from peers or instructors. This principle led to the inclusion of role plays in many of the seminars in the modules; this allowed practice of new techniques in a non-threatening setting.

5) Learning is more likely to occur if the learner has the opportunity to get feedback about new skills. Interchange between learner and

instructor allows the immediate refinement of skills. Good performance can be reinforced, and suggestions for change made where problems exist. Without feedback, the learner does not know if s/he is doing a new skill correctly, and may abandon it because of uncertainty. All of the modules provide the residents with opportunities for feedback. Feedback, if designed to correct a problem, should include specific suggestions for improvement. This allows the resident to make informed changes in her/his behavior.

6) Residents are more likely to retain and utilize skills if s/he has an opportunity to practice those skills more than once. Repetition is certainly an important aspect of learning. The instructional modules often include repetition of objectives in several activities, or reinforcement in later modules to provide the residents with the opportunity to practice a skill in several different situations.

7) Theory must be linked directly to specific implications for practice. Theories about human behavior provide a basis for generalizations about how people act. They are more easily taught to the learner if s/he can see concrete examples of how these theories apply to her/his daily experiences, and how they help explain the human behavior s/he observes.

8) Traditional teaching methods such as lectures or reading are less effective in teaching patient education skills than those which actively involve the learner in testing new ideas and skills through discussion and participation. Patient education skills, like basic skills in physical examination, need to be practiced before they are learned. Lectures and reading may provide background information, but skills are refined through the learner's discussion of her/his own experiences in case presentations or group discussions, and through opportunities for practice in real and simulated settings.

Integration with the Existing Residency Curriculum

The experiences gained from field testing these instructional modules to teach patient education skills has led us to recommend that the modules should be integrated into the existing residency curriculum, rather than presented as separate educational experiences. Integration emphasizes the role of patient education as a part of the entire clinical encounter. Integration has the advantages of increasing acceptance by residents of the instructional activities and involving clinical faculty in the teaching of these activities.

Recommended time frame for implementation of the instructional modules

The instructional modules are designed so that they can be implemented in a variety of ways, to suit the differing needs of residency programs. In a program where residents are separated into first, second or third years of residency for some of their educational experiences (behavioral science seminars, for example), the modules can be spread throughout the three year training period. Module One can begin after the initial adjustment period of first year residents during the first three months of the year. Modules One and Two, dealing with communication skills and psychosocial factors in patient education are ideal for first year residents, for they provide a foundation in patient education yet are not dependent on the residents discussion of actual outpatient experiences. Modules Three, Four and Five do draw on the residents' experiences and assist them in developing strategies for educating patients. These modules are best suited to the second year of residency and the beginning of the third year. Module Six, which addresses incorporating patient education into practice is most appropriate for residents in their third year, although many of the activities can be adapted for residents interested in improving patient education in the model clinic.

In residencies where residents are combined for all their seminars and group activities, the modules can be used differently. Instructors will find that when first, second and third year residents are combined for patient education seminars and activities, residents begin to teach each other. This can be used to great advantage, for first year residents are eager to model themselves upon their more experienced colleagues. The modules are best taught if they are spread out over at least a one year period, to allow time for the individual activities.

When the instructional modules are used in a combined program as described above, the value of their flexibility is apparent. The observation and feedback activities, in this situation, can be adapted to the skill level of the resident, rather than strictly adhering to the objectives of the module. Other individual activities can also be adapted, through use of audiotape or videotape, to supplement the needs of individual residents. A first year resident might benefit, for example, if the patient's comments in the interviews done in Module Three could be compared with a tape of the actual encounter.

The instructional modules can also be adapted for use in a "marathon" program of several days, if reinforcement periods are scheduled. The content of the seminars can be presented together and supplemented by "observations" of videotaped encounters which illustrate the objectives of the modules. If a marathon is presented, however, an effort should be made to continue observations and other individual activities throughout the year.

The program of instructional modules are designed so that they can be adapted to varying time needs of residencies. Many of the seminars include one or two hour options, and activities can be carried out in different ways based on the available faculty time. Although we had hoped to make the modules self-instructional, this was abandoned when we realized the value of role-playing and practice with feedback in learning the special set of skills required in patient education.

Recommendations for staff to implement instructional modules in a residency program

The activities and seminars in each module include specific instructions for the instructor, so that previous in-depth knowledge of the area is not required. The modules have been designed in this manner so that they may be used by a wide range of professionals. Within a particular residency program, use of the therapeutic educational modules could be coordinated by;

a physician
a social worker
a counselor
a nurse educator
a psychologist
a pharmacist
or other professional
or by interested residents

The person who assumes responsibility for the instructional modules should have some training in the behavioral sciences, a strong interest in patient education and a sensitivity to the needs and interests of patients as well as physicians.

The coordinator should be a skilled discussion leader and should be able to identify general principles of patient education within specific case examples. S/he should have credibility with the residents and faculty and should be able to relate well to both groups.

Recommendations for Advertisement and Distribution of the Instructional Modules to Teach Patient Education Skills to Primary Care Residents

The major audience for this document is primary medical care residency programs, although other health professional training programs may also be interested. To reach these groups, announcement of the availability of the "Instructional Modules to Teach Primary Care Residents to Educate Patients" should be made to all family practice residency programs, and to primary care residencies in pediatrics and internal medicine. This announcement can be made through direct mailings or through professional societies, such as the Society for Teachers of Family Medicine or the Society for Research and Education in Primary Care Internal Medicine.

Advertisement of the instructional modules can also be made through Focal Points, the newsletter of the Bureau of Health Education, or through the Physician's Health Education Newsletter.

Presentation of the instructional program, its methods and materials at professional meetings will promote the Instructional Modules. Publication of articles in professional journals is also an effective means of promotion.

The "Instructional Modules to Teach Primary Care Residents to Educate Patients" should be published and distributed through a professional society, such as the Society of Teachers of Family Medicine, or by a university press.

Recommendations for further work

Although this instructional program has been field tested and informally evaluated, we would recommend further evaluation in different sites. To this end, more reliable evaluation tools should be developed to measure changes in the educational skills of residents who participate in the instructional program. An ideal evaluation study would involve an experimental group of several residencies, and a well matched comparison group.

It would also be desirable to adapt and field test this instructional program with medical students and with residents in other primary care specialities.

Finally, we would recommend the development of a series of "advanced" modules in patient education, dealing with issues in wellness, health promotion and occupational medicine, and preparing physicians to train ancillary personnel in patient education skills.

REQUESTS FOR INSTRUCTIONAL MODULES

Information regarding availability of the instructional manual for Instructional Modules to Teach Primary Care Residents to Educate Patients can be obtained from the Department of Family Medicine and Practice, University of Wisconsin, 777 South Mills Street, Madison, Wisconsin 53715. Phone: (608) 263-4550.

REFERENCES

1. Svarstad, B. Patient Compliance with Drug Regimens: An Analysis of Communication Techniques. Hamilton, Illinois: Drug Intelligence Publications, Inc., 1981.

2. Meyer, D., Leventhal, H., and Gutmann, M. Symptoms in Hypertension: How Patients Evaluate and Treat Them. Unpublished manuscript. University of Wisconsin-Madison, 1979.

3. Haynes, R.B., Sackett, D.L., Gibson, E.S., Hackett, B.C., Taylor, D.W., Roberts, R.S., and Johnson, A.L. Improvement of medication compliance in uncontrolled hypertension. Lancet 1:1265, 1976.

4. McKenny, J.M., Slining, J.M., Henderson, H.R., Devins, D., and Barr, M. The effect of clinical pharmacy services on patients with essential hypertension. Circulation 48:1104, 1973.

5. Schulman, B.A. Active patient orientation and outcomes in hypertension treatment: Application of a socio-organizational perspective. Medical Care 17(3):267, March 1979.

6. Noren, J., Altman, I., and DeLozier, J. Ambulatory medical care: A comparison of internists and family general practitioners. New Engl. J. Med. 302:11, Jan. 3, 1980.

7. Platt, F.W., McMath, J.C. Clinical hypocompetence: The interview. Annals of Intern. Med. 91:6, Dec. 1979.

8. Bartlett, E.E. Directory of health education programs in medical education. Physician's Patient Education Newsletter, University of Alabama-Birmingham, August 1980.

9. National Task Force on Training Family Physicians in Patient Education. Patient Education: A Handbook for Teachers. Society of Teachers of Family Medicine, Kansas City, MO, 1979.

10. Residency Assessment Program Guidelines. American Academy of Family Physicians, Kansas City, MO, August, 1978.

11. Golden, A.S. An Inventory for Primary Care Practice. Ballinger, Cambridge, Mass. 1976.

12. Bartlett, E.E. Physician Health Education Competencies. Mimeo. Johns Hopkins School of Public Health, Baltimore, April, 1979.

13. Green, L.W. Educational strategies to improve compliance with therapeutic and preventive regimens: The recent evidence. Compliance in Health Care, Johns Hopkins University Press, Baltimore, 1979.

14. Green, L.W., et al. Health Education Planning: A Diagnostic Approach. Mayfield, Pub., Palo Alto, CA 1980.

15. Leventhal, H. The consequences of depersonalization during illness and treatment. In Humanizing Health Care, edited by J. Howard and A. Strauss. Wiley, New York.

16. Leventhal, H., Meyer, D., and Nerenz, D. The common sense representation of illness danger. In Medical Psychology, edited by S. Rachman. Pergamon Press, New York, 1980, Vol. II.

17. Ley, P. Psychological studies of doctor-patient communication. In Contributions to Medical Psychology, edited by S. Rachman. Pergamon Press, New York, 1977, Vol I, pp. 9-42.

18. Griffiths, H.W. Teaching patient education in a family practice residency program. Patient Education in the Primary Care Setting: Proceedings of a Conference. University of Wisconsin, Dept. of Family Med. and Practice, Madison, Wisconsin, p. 99, 1977.

19. Kluemper, M.A. Personal Communication. University of Nebraska, Dept. of Family Medicine, 1978.

20. Sternburg, J.K. and Brockway, B.S. Evaluation of clinical skills: An asset-oriented approach. J. Fam. Practice 8(6):1243, 1979.

INSTRUCTIONAL MODULES TO TEACH PRIMARY CARE RESIDENTS TO EDUCATE PATIENTS

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MODULE 1

COMMUNICATION AND BASIC PATIENT EDUCATION SKILLS

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INTRODUCTION

In order to reinforce and improve the patient education skills of primary care residents, Module 1 begins with the basic elements of any educational experience: clear communication and the exchange of information. The goal of medical care is the improvement of the health status of those who use it. Such improvement, especially in the primary care setting, depends primarily on the patient following a treatment plan established during the medical encounter. The best advice is worthless if it is not clearly communicated and if it is not understood by the patient.

Module 1 focuses on changing the behavior of the physician rather than changing the behavior of the patient. Early studies of patient adherence to medical regimens looked at the characteristics of patients in an effort to explain their noncompliance. These studies were unable to identify the patient who did not follow recommendations by age, sex, income, or even beliefs (Svarstad 1976, Sackett and Haynes 1976), and thus could not make suggestions to help patients adhere to medical regimens. Recently, however, observations of medical encounters have shown that much of the information provided by the physician is incomprehensible to the patient. These observations also show that the style and content of communications between the doctor and the patient are important in determining the patient's subsequent behavior (Svarstad 1976). The observations point out that improvement in the physician's communication skills can have a major impact on improving patient satisfaction with medical care and adherence to medical regimens.

The focus on increasing physician's skills in communicating with patients implies an assumption that quality medical care includes an active effort by the physician to inform the patient. To do this efficiently and effectively, the physician must learn to present information that is relevant to the patient, in a manner that the patient can understand.

As in each subsequent Module, the content of Module 1 is introduced with a seminar. In the Module 1 Seminar, "Communication for Patient Education" a case presentation and role plays are used to allow residents to rehearse the methods of increasing patient comprehension and recall that are described in a didactic presentation. An observation and feedback activity provides each resident an opportunity to receive individualized feedback on her or his skill in using these communication and basic patient education techniques with clinic patients. The Appendix to Module 1 provides complete instructions for carrying out the Observation and Feedback Procedure, along with an outline for a workshop to train observers. Prior to a second seminar, residents are asked to follow a seven-day sugar pill regimen. Residents are then asked to discuss their own experience in order to identify problems that patients face in adhering to medical regimens, along with strategies physicians can use to help patients overcome these problems.

OBJECTIVES FOR MODULE 1

Residents will demonstrate an ability to:

1. Explore the patient's reason(s) for visit;
2. Use open-ended questions throughout the visit;
3. Use terminology and concepts familiar to the patient throughout the visit;
4. Inform the patient of any findings;
5. Explain the treatment plan in terms of specific behaviors;
6. Encourage and respond to questions from the patient;
7. Assess the level of the patient's understanding about the condition and treatment plan by asking appropriate questions;
8. Summarize conclusions and instructions for the patient at the end of the visit;
9. Provide the patient with written instructions.

DISCUSSION OF MODULE 1 OBJECTIVES

1. *Residents will explore the patient's reason(s) for visit.*

Although clinic procedures may require identifying a single "reason for visit," a patient often has many concerns which are easily overlooked if the patient is not given an opportunity to introduce and discuss additional concerns. Basic medical interviewing texts such as Enelow and Swisher (1979) suggest open-ended questions early in the encounter, such as, "What kinds of trouble have you been having lately?" The roles of the participants must be recognized as Platt and McMath (1975) state, "The patient's job is to tell his story and the physician's job is to listen and hear." The patient's story is the source of useful clinical data. Careful exploration of the patient's reasons for seeking care will identify the patient's priorities for this visit. Failure to identify and address these concerns leads to dissatisfaction (Korsch et al., 1971) and nonadherence to treatment recommendations (Francis et al., 1969).

2. *Residents will use open-ended questions throughout the visit.*

An important medical interviewing skill is the ability to use open-ended questions to elicit information from the patient (Enelow and Swisher, 1979). Although this technique is most often suggested for use during early stages of the interview, its use throughout the visit will improve communication between patient and physician. While direct, closed questions are needed at times to focus on omitted or necessary information, in general, open-ended questions are less biased and allow for more patient participation in the encounter. For example, "So you're here for the immunizations?" can be answered in the affirmative, but fails to uncover other concerns that actually brought the patient in; for example, a behavior problem about which the patient may be worried.

Similarly, open-ended questions during the history often uncover useful medical information: "What makes the pain better...worse?" This question can uncover the patterns in the pain and any treatments the patient may have tried. The problems with close-ended adherence questions have been well documented (Sackett, 1978). "You're taking your medicine four times a day?" is a question that implies an affirmative answer as the only correct response. A question such as "What do you do when you miss your medicine?" acknowledges problems the patient has in following a strict medical regimen.

Finally, open-ended questions at the end of the visit are necessary to assess whether the plan has been clearly understood and agreed upon. Questions at that point might be: "What problems do you see in taking the medicine?" or simply, "What questions do you have about today's visit or the plan?" Clearly, close-ended questions are necessary during clinical encounters. However, such questions often introduce bias into the patient's response which leads to inaccurate or incomplete information for the physician. The objective is for the resident to use open-ended questions as much as possible throughout the visit.

3. *Residents will use terminology and concepts familiar to the patient throughout the visit.*

Studies have demonstrated that physicians use terms and concepts that patients do not understand (McKinlay, 1974; Svarstad and Lipton, 1977; Samora et al., 1961; Ley, 1977). Technical medical terms and jargon can confuse and intimidate patients who often do not press for explanations because of embarrassment or misinterpretation of the words. For example, "Your belly is soft" may connote good bowel function to the physician, but poor muscle tone to the patient. Although the patient wants to know the diagnosis, telling her, "You have fibrocystic disease" can cause needless anxiety in the patient. Such a diagnosis requires a simple, nontechnical explanation; for example, "... a common condition of thickened muscle fibers in the breasts which makes it harder to do breast self-examinations but doesn't in itself cause any problems."

It is obvious that a strange vocabulary is an impediment to communication. The resident needs to become aware of and alter her or his vocabulary so that s/he and the patient have a shared understanding of the condition and the plan.

4. *Residents will inform the patient of any findings.*

First, the patient has a basic right to medical information, including physical findings. Second, when this information is withheld during an examination, the patient can become needlessly anxious or distrustful of the physician, or misinterpret non-verbal cues, such as smiles or frowns (Ley, 1975). Finally, studies by Francis et al. (1969) and Korsch et al. (1971) demonstrated that patients expected to learn the diagnosis and cause of illness and when they did not, they were less apt to follow the doctor's advice. This can be efficiently done as the examination progresses.

Informing the patient of any findings can also provide specific feedback on progress toward a treatment goal: "Your blood pressure today is 135/95. That's much better than the 160/105 reading when treatment started, but not quite down to your goal of 120/90." This reinforces the patient's efforts and provides a much clearer message than simply saying, "It's much better" or "It's going down." Thus, telling the patient the findings of the physical examination can reassure the patient and reinforce the treatment plan.

5. *Residents will explain the treatment plan in terms of specific behavior.*

General or vague instructions can be interpreted in different ways by different patients. In order to avoid this problem, the resident should give specific instructions in terms of behaviors that are necessary to the plan (Ley, 1969). For example, "Don't do any lifting" can mean not lifting anything to one patient and not lifting anything more than 50 pounds to another. A better regimen would be, "Don't lift anything over ten pounds." Similarly, the instruction, "Feed the baby more often so s/he will gain weight," should be in terms of specifics: "Besides what you're feeding now, give the baby ___ ounces of formula at each feeding. If s/he hasn't gained ___ lbs. in three weeks (next visit) we'll try something else." The more specific the instructions, the more likely it is that the patient will understand and follow the plan.

6. *Residents will encourage and respond to questions from the patient.*

Svarstad (1974) and others have documented the need for encouraging questions and discussing them with the patient. Since a shared understanding is necessary for informed decisions by patients, questions should be encouraged to clarify misunderstandings or misconceptions (Enelow and Swisher, 1969). Indeed, questions posed by patients are excellent educational opportunities. When questions are ignored or discouraged, the patient may not follow through with the treatment plan, or might change physicians. An excellent technique to encourage questions is saying to the patient after the physical examination, "I'll leave the room while you're getting dressed. Think about any questions you might have and ask them when I come back."

7. *Residents will assess the level of the patient's understanding about the condition and treatment plan by asking appropriate questions.*

Even though the resident may be careful to use familiar terms and concepts, inform the patient of findings and explain the regimen in clear and specific behaviors, the resident cannot assume that the patient understands the condition and regimen (see Ley, 1977). The patient's understanding must be directly assessed by asking questions: "So what does diabetes mean to you? . . . How will you manage taking the insulin three times a day?" Although some residents may be reluctant initially to ask such questions for fear that they sound paternalistic or that they waste time, the patient's response demonstrates how useful the technique is. The assessment uncovers incorrect assumptions about conditions: "No, just taking it easy on the job won't help your blood pressure." The assessment also uncovers incorrect assumptions about treatment: "Yes, you'll need to keep taking the pills even though you'll begin to feel better." These provide direct feedback on patient education efforts.

8. *Residents will summarize conclusions and instructions for the patient at the end of the visit.*

A concluding summary may appear to be redundant and an inefficient use of time but it is important for several reasons. First, it presents the resident's perception of the behaviors expected of the patient. Second, since instructions are difficult to remember, repetition stresses the importance of the instructions (Bradshaw et al., 1975; Svarstad, 1974). Finally, the summary provides closure on the visit so that the patient understands the problems as well as the plans designed to meet them.

9. *Residents will provide the patient with written instructions.*

Patients retain only a small proportion of the information from a visit (see Ley, 1977). They tend to remember the initial information (e.g., the diagnosis) rather than the later information (e.g., the plan). Therefore, written instructions provides the patient with a record as well as a reminder of the instructions. Also, taking time to write the instruction stresses its importance to the patient. At the University of Wisconsin, the clinic notes include a carbonless instruction sheet that automatically produces a copy on chemically treated paper. This copy remains in the clinic chart, providing both the patient and the physician with a written record of the treatment plan.

The above objectives are not a complete list of behaviors indicative of communication skills expected of residents. However, they do present a set of criteria that should improve the exchange of information between physician and resident.

SEMINAR FOR MODULE 1

COMMUNICATION FOR PATIENT EDUCATION

The goal of this seminar is to provide the resident with an overview of the components of effective communication and patient education skills through case discussion, didactic presentation, and role play practice. The case discussion allows residents to share ways they educate patients about a common, yet medically complex, issue. During this discussion, the seminar leader identifies and reinforces strategies used by the residents which enable a patient to understand and remember instructions about a regimen. Research on methods of increasing comprehension and recall of instructions for medical regimens is the topic of the short didactic presentation. Finally, in the role plays, residents have the opportunity to practice the strategies discussed in the earlier parts of the seminar.

OBJECTIVES

The resident will discuss and demonstrate strategies that facilitate the patient's understanding and recall of information including:

1. Organizing information by category;
2. Using terminology familiar to the patient;
3. Justifying the regimen to the patient;
4. Providing specific instructions to the patient;
5. Giving the patient written instructions;
6. Assessing patient understanding of information.

PREPARATION OF THE SEMINAR LEADER

The methods for improving physician-patient communication which are discussed in this seminar are taken primarily from P. Ley's "Psychological Studies of Doctor-Patient Communication." This chapter can be found in Contributions to Medical Psychology. The leader will find it helpful to read this chapter before giving the seminar. Supplemental readings are also cited in the "Discussion of the Objectives" for this module.

Before presenting this seminar to first-year residents, the leader may find it helpful to review the characteristics and treatment of gall bladder disease and hyperbilirubinemia, the two clinical conditions used in the role plays. Often, first-year residents have not yet acquired this information.

Depending upon the clinical experience and the interest of the residents, the leader may choose to ask a resident to present either the didactic section or the case discussion.

PREPARATION OF THE RESIDENTS

Residents who would like background material for this seminar can be referred to the "Discussion of the Objectives" for Module 1. Two other readings which discuss the major points of the seminar are "Psychological Studies of Doctor-Patient Communication," by P. Ley in Contributions to Medical Psychology and "Recall of medical advice: comprehensibility and specificity," by P.W. Bradshaw and his colleagues in the British Journal of Social and Clinical Psychology (see Bibliography).

SEMINAR OUTLINE

I. Case Discussion

A. Present this case to the residents:

> You are about to prescribe birth control pills to a healthy, married, 20 year-old woman who smokes a half-pack of cigarettes a day. She has never taken birth control pills. As her physician, what do you want her to know before she leaves your office?

B. Replies to "What do you want her to know?" might include:

1. How to use the pill, including:
    - a. Regular time of day.
    - b. What to do if she misses a day.
    - c. Backup method of contraception.
2. How the pill works, in simplified terms.
3. The health risks of the pill, with special emphasis on hazards for women who smoke.

C. For each reply a resident gives to "What do you want her to know?"

1. Ask, "What would you say about this?"
2. Ask several residents to present the same category of information. This will demonstrate alternate ways of discussing each category, such as "How the pill works."
3. Ask residents to present the information as if they were talking to a patient.
4. Encourage the residents to use nontechnical terms, simple concepts, and clear and explicit instructions.

D. Discuss different approaches the residents used to present information and instructions pertaining to the birth control pill.

1. Point out how explanations were understandable, and how explanations could be less technical.

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2. Point out recall strategies used by the residents.

3. Discuss specificity of the instructions.

4. Emphasize importance of using these strategies to communicate effectively about any medical regimen.

II. Didactic Presentation

A. Communication for Patient Education

1. Effective practice of patient education is based on clear communication, including the ability to listen to and hear the patient.

2. Choice of information and instructions regarding the regimen should be based on an assessment of the patient's understanding and needs. In most cases, the patient should be involved in decisions about the regimen, as the patient can identify potential problems in following the regimen.

3. Research has shown that patients often do not understand, or are unable to recall, physicians' instructions and explanations. (Ley, 1977)

4. Often, a patient's failure to understand is related to three major factors:

   a. Material presented is too difficult for the patient to comprehend.
   b. Patient lacks technical medical knowledge.
   c. Patient holds beliefs about physiological functions and treatments which conflict with the explanations offered by the physician.

5. There are ways to improve comprehension and recall. If we look only at physician-related factors we can identify some things which the physician can do to make the patient's task of understanding easier.

   a. The first way to increase understanding and recall is to categorize information. Basically, this is "talking in subheadings." Instructions and explanations should be explicitly labeled. The following introductions help to organize:
      Let's talk about: What is wrong with you.
      What tests will be needed.
      What will happen to you.
      What treatment you will need.
      What you can do to help yourself.
   b. Repetition of important instructions or facts facilitates recall. This can be accomplished in two ways. The physician can summarize any important instructions or facts at the end of the encounter; e.g., "So, take one pill four times a

day, every day until the pills are all gone. If you don't feel better in four days, or if you feel worse, call me at the clinic." Alternatively the physician can ask the patient to repeat instructions. Some questions to ask the patient are: What will you do to treat this problem?
When will you take your medicine?
What will you do if you forget a pill?

c. The importance of instructions should be stressed. One way to stress the importance of instructions is to repeat them. The physician can tell the patient how important it is to follow instructions. For example, "If you don't take all of the pills, you may get sick again. It will take all of the pills to kill the bug you have."

6. Provide written instructions: Take penicillin, one pill, four times a day, every day until all the pills are gone. Written instructions are a reminder that the patient can take home, and use to carry out the regimen.

III. Role Plays N.B. If the leader has only 60 minutes to present this seminar, one role play can be removed from the seminar outline.

A. Ask the residents to divide into pairs for role plays. There are physician and patient roles for each role play, "Who is Billy Rubin?" and "Mrs. Smith's Gall Bladder." Each role play should last between five and ten minutes.

B. After the first role play, ask residents to exchange roles. This will allow each resident to experience the problems of explaining and understanding.

C. Discussion can take place after both role plays have been completed or after each role play.

D. When giving residents instructions for role playing, ask them to try to "forget" their medical knowledge when playing the role of the patient.

*****

Role Play: Who is Billy Rubin?

Patient Role

You have become the father (mother) of a beautiful 7 lb., 1 oz. baby girl, your first child. The delivery went smoothly and you and your spouse are excited about taking the baby home. This morning you heard the nurses whispering about your baby and you suspect there may be something wrong. Your sister's baby had to stay in the hospital for two weeks and by the

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time the baby came home she was unable to nurse the baby. That worries you for your wife (you) had planned to nurse and in preparation had attended La Leche meetings.

You (your wife) saw the doctor regularly for prenatal care and you both trust your doctor.

You might wonder:
Is your baby normal - will she be mentally retarded?
Does she have a common problem?
If the baby has to stay in the hospital can she still be breastfed?
Who is Billy Rubin?

(Father - factory worker with high school education, good health insurance; mother - high school education, has worked as secretary)

Physician Role

Your patient gave birth yesterday to a 7 lb., 1 oz. baby girl. The mother is doing fine, but the baby has an elevated bilirubin and will need to be kept in the hospital for several days more for treatment. You are reasonably sure the baby has physiological jaundice which can be taken care of simply.

You know that your patient has a high school education, works and has good health insurance. The couple seem to have a good relationship and both have been actively involved preparing for this first baby. The mother has been attending La Leche meetings and is eagerly anticipating nursing the baby.

Role Play: Mrs. Smith's Gall Bladder

Patient Role

You are a moderately overweight 55-year-old woman with four grown children. For the last three days you have been experiencing sharp pains in your right side. The pains seem to have started three days ago after eating short ribs for dinner. Since then you served ham for dinner, but it made you so sick you had to leave the table and lie down. Since yesterday you have eaten only tea and toast.

You have had some pain in your side previously, but it has always gone away in a day or so. You prefer to stay away from doctors and medicines. This time your family made you come in. They say they have never seen you so uncomfortable. You are sure it is really nothing. On the other hand, you are a little worried.

Physician Role

Mrs. Smith is 55 years old, has four grown children, and is moderately overweight. She and her husband run a farm outside of town. She is in your office complaining of sharp abdominal pains which increase and decrease in intensity. She reports that they are worse when she eats foods like ham or short ribs, or rich desserts.

Mrs. Smith has not seen a doctor for 15 years and does not like to take medicines. You understand that her family virtually forced her to come in today.

You suspect that she is having a gall bladder attack. Your first line of treatment is pain pills, before an x-ray study. If gall stones are found, she will need surgery.

IV. Discussion of Role Plays

A. Encourage residents to discuss role plays.

1. Questions the leader can ask about the role of physician:

   a. What did you have trouble explaining?
   b. What words were difficult to explain?
   c. What concepts were difficult to describe simply?
   d. What strategies did you use to make it easier for the patient to remember instructions?
   e. What did you do that you would do differently next time?

2. Questions to ask about role of patient:

   a. What did you have trouble understanding?
   b. Were you aware of any explanations or words which you would not have understood if you weren't a physician?
   c. Were you given specific instructions?
   d. What were they?
   e. What did you understand your problem to be?
   f. Did the physician assess your understanding of his instructions or explanations?
   g. How was that done?

OBSERVATION AND FEEDBACK ACTIVITY FOR MODULE 1

The goal of this activity is to identify the Module 1 objectives each resident has begun to practice, and to assist the resident in incorporating into practice the objectives s/he has yet to apply. Since this is the first time each resident is observed, the observer will be able to assess each resident's skill level of patient education. These skills are noted and reinforced by the observer during the verbal feedback sessions. Specific instances of each resident's deficits in applying basic patient education and communication strategies are also noted. The observer makes specific recommendations for improving the skills which a resident has not yet mastered.

N.B. This section does not include instructions for either using the observation protocol, giving feedback, or the mechanics of the observation and feedback procedure. This information is given in Appendix A "Instructions for the Observation and Feedback Procedure." Read these "Instructions for the Observation and Feedback Procedure" BEFORE you read instructions for the Module 1 Observation and Feedback Activity, (page 31).

During this activity, the observer pays particular attention to the resident's performance of the criteria which correspond to Module 1 objectives:

A.2. Did resident ask open-ended questions?

A.5. Did resident use words the patient could understand?

A.6. Did resident tell patient what s/he was doing/examining?

A.7. Did resident tell patient what s/he was finding?

B.1. Did resident encourage/respond appropriately to patient questions?

B.2. Did resident present information consistent with patient's needs (content/amount)?

B.3. Did resident justify regimen to patient?

C.1. Was advice specific/concrete?

C.2. Was patient provided with written instructions?

C.6. Did resident repeat conclusions/instructions at end of visit?

PREPARATION OF THE OBSERVER

Carefully read all of the Module 1 materials in this manual. Pay particular attention to the Module 1 "Discussion of Objectives," "Role of the Clinical Faculty," and the "Justification of Criteria." The materials provide specific examples, references to relevant research studies, and a logical justification for each behavior described in the Module 1 objectives and the observation protocol criteria.

Study the readings that discuss the importance of the objectives of Module 1. The *Physician's Guide to Compliance in Hypertension* by Richard Podell contains a concise review of major theories and studies of patient compliance. Podell discusses the effect of physicians' behavior on patient compliance and makes recommendations for treating and preventing patient noncompliance. P. Ley's chapter, "Psychological Studies of Doctor-Patient Communication," gives a brief description of research in doctor-patient communication along with practical advice for increasing a patient's recall and comprehending a physician's statements. *Interviewing and Patient Care* by Enelow and Swisher discusses the basic aspects and techniques of medical interviewing.

When co-workers, friends or relatives describe their experiences with physicians, listen for examples of Module 1 objectives. Note, for instance, whether specific instructions were given to these people. Thus, a list of examples, both positive and negative, can be generated for each Module 1 objective. In the process of gathering the examples, you will sharpen your skills at quickly identifying these statements and behaviors. This will prepare you to use the observation protocol. You can use the examples as a teaching tool when giving feedback.

PREPARATION OF THE RESIDENT

Before starting to observe and give feedback, discuss the following aspects of the Observation and Feedback Activity with the residents:

1. The observation protocol is not an evaluative test but an educational tool. It allows the observer to record the skills of a resident as well as the areas in which the resident can improve in a systematic manner.

2. Observers do not interact with the patient; rather, they sit in a corner of the room and take notes.

3. Observations generally take place over several consecutive visits. This allows the observer to ascertain a resident's performance in a variety of situations, and to gain a more accurate perception of each resident's skills.

4. The patient's permission is always obtained. Patients have a right to refuse to be observed. (Also tell patients that they can ask an observer to leave at any time.) Either the resident or the observer can request permission from each patient.

5. Observers will give residents specific feedback along with suggestions for improving each visit.

6. The resident and the observer decide together when to schedule feedback sessions.

7. During the Module 1 Observation and Feedback Activity, observers will focus attention on the following criteria from the observation protocol:

   Did resident ask open-ended questions?

   Did resident use words the patient could understand?

   Did resident tell patient what s/he was doing/examining?

   Did resident tell patient what s/he was finding?

   Did resident encourage/respond appropriately to patient questions?

   Did resident present information consistent with patient's needs (content/amount)?

   Did resident justify regimen to patient?

   Was advice specific and concrete?

   Was patient provided with written instructions?

   Did resident repeat conclusions/instructions at end of visit?

INSTRUCTIONS FOR OBSERVATION AND FEEDBACK ACTIVITY

Follow the Observation and Feedback Procedure instructions in the Appendix to Module 1 in order to:

1. Schedule observation and feedback sessions.
   N.B. Any type of patient visit can be observed. Communication and basic patient education skills are necessary components of any physician-patient encounter.

2. Observe each resident for at least three encounters.

3. Fill out an observation protocol for each encounter.

4. Prepare written feedback for each encounter.

5. Give each resident written and verbal feedback for each encounter.

When filling out the observation protocol:

1. Fill out the entire Behavior Checklist.

2. Record under "Examples" resident statements and behavior which are connected to the Module 1 observation protocol criteria.

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When preparing feedback:

1. Label the behavior you wish to discuss.
   Example: "The instructions you gave were vague."

2. Cite a specific example of the behavior from the encounter.
   Example: "Do no lifting for one week."

3. Justify the importance and impact of the behavior.
   Example: "This could be interpreted in many ways by the patient: I'll only lift what I have to; I shouldn't lift my body out of bed; I shouldn't carry anything; I can lift my baby, but nothing else..."

4. Give a specific suggestion for change for each skill that you want the resident to improve.
   Example: "It would be easier for the patient to follow instructions if you were more specific, for instance: Don't lift anything that weighs more than two or three pounds, like a telephone."

Refer to the readings cited in "Preparation for Observation and Feedback Activity" for assistance in identifying a rationale or example for any of the criteria for Module 1.

During verbal feedback, stress the connection between the behaviors you discuss and the material presented in the Module 1 seminars. You may also wish to suggest that a resident read Podell (1976) for a discussion of the effect of physicians' behavior on patient compliance and methods of treating and preventing patient noncompliance. As an alternative, you could suggest that the resident read the "Justification of Criteria," (page 41) or the Module 1, "Discussion of Objectives" and the "Role of the Clinical Faculty."

SEMINAR FOR MODULE 1

PATIENT ADHERENCE TO MEDICAL REGIMENS

This seminar continues an exercise in adhering to a medical regimen. It discusses the problems a patient faces in sticking to regimens and the strategies used to make adherence easier for the patient. Concepts from the first seminar are reviewed and their application to improve adherence is reinforced.

The goal of this seminar is for residents, by observing their own behavior, to understand the problems a patient encounters in following medical regimens. They will be able to develop methods for preventing these problems.

OBJECTIVES

1. The resident will be able to identify problems a patient has in adhering to a regimen.
2. The resident will list strategies to make following a regimen easier for a patient. These include providing specific instructions, providing written instructions and justifying the need for the regimen.
3. The resident will list open-ended questions to assess patient adherence.
4. The resident will be able to demonstrate questions to assess the patient's understanding of treatment plan.

PREPARATION OF THE SEMINAR LEADER

To prepare for this seminar, the leader should review the literature on patient compliance. Podell (1975) and Sackett (1978) have written on strategies that physicians can use in improving patient compliance.

Two weeks before the seminar, the group leader needs to prepare the "medications" the residents will be taking. Dynamints look like pills, are reasonably inexpensive, and easy to obtain. (This exercise was once tried with M & M's and there was no adherence!) Obtain small pill bottles (preferably with baby-proof tops) and labels for each resident, and an adequate number of Dynamints to provide 30 for each resident and faculty participating in the seminar. Put 30 Dynamints in each pill bottle. Prepare the labels:

For (resident's name)

Lipragus. Take 4 a day for 7 days.

(your name)
(date)

Lipragus is sugar pil(l) spelled backwards.

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One week before the seminar, distribute pill bottles to each resident. Explain that these are sugar pills, but they should take them as directed to prepare for next week's discussion of patient adherence.

If a resident cannot be contacted in person, put the pill bottle and written instructions in the resident's mailbox.

With a large group it is possible to experiment with different instructions. Variations include:

One pill every 6 hours for 7 days.
One pill 4 times a day for 7 days.
Take as directed.

It has been found that less than one-third of the residents take the pills for seven days and that at least one-third take none (as the literature suggests). This should be considered in the decision to provide different instructions.

This seminar can be presented as a didactic seminar or as a problem-solving session. The leader should review the literature on compliance presented in books such as Compliance in Health Care by Haynes et al. (1979) to decide the approach to take. The outline of the seminar following the exercise below is left vague on purpose in order to allow the leader to select an approach. Even in a didactic presentation, however, it is important to allow the residents some time to discuss their own experiences as doctors and patients.

Be sure to invite an experienced clinician to participate in your seminar. The clinician's contribution will be valuable.

PREPARATION OF THE RESIDENT

One week before the seminar give each resident the pill bottle with Dynamints. Justify the regimen: "This is preparation for next week's seminar on adherence to medication regimens. Please take 4 pills a day for 7 days. Bring your pill bottle to the seminar. Continue pills even if you feel better." An appropriate reading for the residents is Sackett (1978).

SEMINAR OUTLINE

I. Discussion of Pill-Taking Activity

A. Assessing adherence. The seminar leader models the assessment of adherence in determining how the residents took their "pills."

1. Questions to ask include:

How did you take your medicine?
Was there any dosage you were likely to miss?
What did you do when you missed a pill?
Did you have any reminders which helped you take your pills?

What did you tell your spouse you were doing?
Did your spouse help or hinder your medicine taking?
What made it difficult for you to take your pills?
What problems did you have taking medicines?
Was it harder to take your pills when your symptoms went away?

2. Discuss similarities between the resident's difficulties in following regimen and the patient's difficulties with regimens. Examples include:

   a. Difficulty remembering.
   b. Hectic, irregular schedules.
   c. No clearly justified reason for taking medicine.
   d. No obvious benefits from taking medicine.
   e. Losing pill bottles.
   f. Doubling up to make up for missed dosages.

B. Strategies to improve adherence. For each of the reasons for non-adherence, the group can develop a strategy for improvement.

Reasons	Strategy
Forgot	Devise reminder system, such as check sheet
Did not believe in importance	Justify regimen by explaining relation to medical findings
Forgot one, so stopped	Explain what to do if pill missed
Doubled up on dosage (2 twice a day)	Provide more explicit instructions

II. Discussion of Research on Compliance

A. Assess and discuss resident's perceptions of compliance rates.

1. How many of your patients adhere completely?

2. Literature suggests one-third always take their medicines, one-third do sometimes, and one-third never take their medicines (Gordis et al., 1969).

3. Doctors generally overestimate compliance of their patients (Caron and Roth, 1968).

   a. Because many noncompliers do not return.
   b. Because many who do not follow instructions do not tell doctors.

B. Research has been conducted on strategies to improve compliance.

1. Teaching patients more.

    a. Studies have found that knowledge of disease is not consistently related to compliance (Tagliacozzo and Ima, 1980; Sackett, 1976).
    b. Out-of-control diabetics tend to have more factual knowledge than controlled diabetics because they are instructed every time they are found uncontrolled (Watkins, et al., 1967).

2. Assessing and reinforcing compliance at short, regular intervals.

    a. Although teaching methods and content varied across compliance demonstration projects, regular (about every two weeks) contact seemed to be an important factor in increasing compliance. (McKinney, et al., 1973).
    b. When frequent contact stopped, compliance dropped.

3. Emphasizing the importance of instructions, by repetition and written reminders.

    a. Studies suggest that about one-half of what doctors say is forgotten immediately (Joyce, et al., 1969).
    b. Repetition of information in a diet leaflet led to more weight loss (Ley, 1977).
    c. Written instructions can be repeatedly referred to by the patient (Sharpe and Mikeal, 1974).

4. Simplifying the regimen to facilitate adherence.

    a. The more drugs a patient is taking the more errors s/he makes (Hulka, 1979).
    b. The more times a day the patient takes a medicine, the more errors s/he makes (Hulka, 1979).
    c. Because taking medication is simpler than changing working or eating habits, medication regimens are followed better (Hogue, 1979).

5. Assessing compliance at follow-up to correct errors.

    a. Physicians frequently do not assess (Svarstad, 1974).
    b. Patients who admit nonadherence are most amenable to compliance enhancing efforts (Sackett, 1978).

III. Who is Responsible for Insuring that Patients Follow the Regimen?

A. Ask residents: How do you feel when your patient doesn't follow your recommendations?

1. Frustrated, angry - "The patient isn't doing what s/he should."

2. Guilty - "What did I do wrong?"

3. Hopeless, helpless - "What more can I do?"

B. One strategy for dealing with these feelings is for the resident to review the mutual responsibilities of the physician-patient relationship.

   1. The resident might ask, "Have I given the patient the information, encouragement and methods to carry out the plan?" If so, the plan may need to be modified to more closely address the patient's concerns. If the resident feels that modifying the plan is medically inappropriate, s/he may wish to review with the patient the mutual responsibilities of the relationship. Explicit and appropriate medical planning that is disregarded represents wasted time for the physician and the patient.

C. Discuss the physician's role in working with an active decisionmaker.

   1. Provide several options for treatment if possible.

   2. Justify each option for treatment and discuss its strengths and weaknesses.

   3. Prepare patient for symptoms and side effects.

   4. Rehearse the plan with the patient.

   5. Ask about potential problems with adherence to the treatment plan.

IV. Let Residents Summarize Seminar Points

V. Give Residents Seminar Handout

SEMINAR HANDOUT:

QUESTIONS TO ASK TO ASSESS ADHERENCE

A. Many people miss taking their medicine sometimes - what are some things that keep you from taking yours?

B. Here are some reasons other people have told us. Do you miss taking your medicine because:

1. It makes you feel funny?
2. You don't think it is helping?
3. You run out of medicine?
4. You get wrapped up in other things?
5. It is too expensive?
6. Anything else?

C. On the average, how many times do you miss taking your pills per week?

D. A professor friend of mine has high blood pressure and he told me he has tried taking less of his medicine to see if he could do as well on less - Have you done something like that?

Answer - No -- Never?
Answer - Yes - What did you do?
What happened?
Do you still do that?

E. What do you do when you miss a pill or two?

THE ROLE OF THE CLINICAL FACULTY FOR MODULE 1

The physician's ability to communicate clearly is an essential aspect of good patient education and good medical care. Residents learn how to communicate as physicians by observing other physicians, and by discussing patient problems. The clinical faculty in a primary care residency are role models for the residents and convey their attitudes about communication and patient education when they see patients with residents and when they teach.

Too often the skills needed to communicate clearly and to educate patients are dismissed as the "art of medicine" that can only be acquired through years of experience and therefore are not formally addressed. We believe that residents can learn the art of communicating clearly. These issues need to be specifically discussed during their medical training. The outpatient setting provides the opportunity for faculty physicians to demonstrate and justify the importance of good communication skills.

This section is designed to provide the clinical faculty with suggestions for demonstrating clear communication and basic patient education skills to residents in the outpatient clinic. It is the first of six in the program Instructional Modules to Teach Primary Care Residents to Educate Patients. The topic of the first module is basic patient education skills; subsequent modules address the patient's perception of illness, strategies for patient education, and practice management. The "Role of the Clinical Faculty" for each module contains a discussion of the patient education skills taught in the Module, along with suggestions for teaching those skills in the outpatient clinic.

The activities in Module 1 are designed to increase the likelihood that residents will be willing and able to:

1. Inquire about the concerns a patient wants addressed during the visit;
2. Ask open-ended questions throughout the visit;
3. Use terminology and concepts familiar to the patient;
4. Inform the patient of any findings;
5. Explain the treatment plan in terms of specific behaviors;
6. Encourage and respond to questions from the patient;
7. Assess the level of the patient's understanding about the condition and regimen by asking appropriate questions;
8. Summarize conclusions and instructions for the patient at the end of the visit;
9. Provide the patient with written instructions.

METHODS OF TEACHING PATIENT EDUCATION SKILLS IN THE OUTPATIENT CLINIC

1. *Inquire about the concerns a patient wants addressed during the visit.*

Starting each visit with open-ended questions about a patient's concerns sets the agenda for the rest of the visit. The use of questions such as, "What brought you here today?" provides the patient with an opportunity to list issues of concern before the resident begins to collect more detailed data. Most clinic receptionists ask about the purpose of the visit when a patient calls to make an appointment. The answer noted on the schedule is not always accurate or complete. Responding to this written information, a resident might say to a patient, "I see you're in for your cold. How long have you had it?" By asking this question, the resident is assuming that the patient came in only for a cold, which may not be true. This question also does not invite the patient to express any other concerns. When seeing a patient with a resident, demonstrate the use of open-ended questions to inquire about a patient's problems. Asking a patient, "What can I do for you today?" may elicit new information about a patient's problems or concerns.

2. *Ask open-ended questions throughout the visit.*

Open-ended questions are especially useful for the following purposes: efficiently obtaining complete and accurate information about a patient's problem, assessing patient compliance to therapeutic regimens, and assessing a patient's understanding of a condition or regimen.

Asking questions like, "How does it feel?" or "Tell me about..." is a more efficient and accurate method of gathering information than is asking a long series of direct questions such as, "Is the pain sharp or dull?" or "Does it hurt on the left side or the right side?" These types of direct questions also force a patient to choose between two answers neither of which may be correct. When you see a patient with a resident, demonstrate the use and benefit of open-ended questions. The residents will see that patients who are asked questions such as, "When do you take your pills?" and "What problems have you had in taking your pills?" will give very different answers than patients who are asked, "You've been taking your medicine, right?" or "Have you been taking your medicine?"

3. *Use terminology and concepts familiar to the patient.*

A patient often does not understand some of the more common terms and concepts used by the physician. For example, a patient may know that kidneys are part of the human body without knowing where kidneys are located or what their function is. When told, "Your belly is nice and soft," a patient is likely to understand the literal meaning of the phrase while having no idea of the medical meaning of the phrase. If a resident uses technical terms and concepts, the patient will be unable to understand or follow the resident's explanations and instructions.

Help a resident to become adept at using simple language when talking with patients. When you see a patient with a resident, note any terms or concepts used by the resident which you believe the patient is unlikely to understand. This can be handled in several ways. You can ask the patient, for example, "What is your understanding of what the kidneys do?" or "What does kidney disease mean to you?" If the patient's answer reflects a misunderstanding, you can explain the term or concept to the patient in clear, simple language, thus providing a model for the resident. Or, you can meet with the resident at a later time and discuss alternate ways of explaining difficult terms and concepts. This method allows the resident to practice using simple language to explain.

Often a resident will consult with you about a patient whom you have not seen. At this time, you can ask the resident, "How will you explain the diagnosis and the possible treatment options to the patient?" If the resident has difficulty doing this, suggest ways to use simple terms and concepts to explain the diagnosis and the possible treatment options. This may also be a good time to suggest the use of diagrams to clarify an explanation.

4. *Inform the patient of any findings.*

A patient has a right to information about her or his physical condition. This information provides a patient with a basis for making decisions about health care. It is not adequate simply to describe the findings of the physical examination without explaining the meaning of the findings.

When a resident relates the findings of a physical examination to a patient without also explaining the meaning of the findings, the patient is not given sufficient information to make any decisions about following a treatment plan. A patient will not be able to understand the significance of a blood pressure reading of 160/100 without the explanation that 160/100 is a high reading compared to a normal reading of 140/90. The patient has no logical reason for following a hypertensive regimen if s/he does not know that s/he has high blood pressure. Anxiety, mistrust, and misinterpretations can occur when a patient is not given an explanation of the findings of the physical examination. A pregnant patient is likely to become anxious if she is told, "Your baby's heart rate is 145," because 145 is a high pulse rate for an adult. A simple explanation will reduce the mother's anxiety: "The normal range of heart rates for a fetus is 140 - 160, so your baby's heart rate is perfectly normal."

When you examine a patient to verify a resident's clinical findings, you can give the patient concise explanations of physical findings. This provides an example for the resident to follow. When you consult with a resident outside the examining room, you can ask the resident, "How will you explain your clinical findings to the patient?" Your concern emphasizes the importance of explaning physical findings and gives the resident a chance to practice giving a nontechnical explanation.

5. *Explain the treatment plan in terms of specific behaviors.*

General instructions can be interpreted in many ways; for example, a patient could interpret, "Get plenty of rest" to mean "I shouldn't get out of bed unless I have to go to the bathroom," or "I can go to work, but I'll go home and lie down if I get dizzy," or "I should get an hour of extra sleep every night." When you see a patient with a resident give the patient detailed instructions: "Take one pill four times a day for ten days. It doesn't matter what time of day you take the pills, but allow three hours to pass between pills." This gives the resident an example to follow. When you consult with a resident outside the examining room, you can ask the resident, "What instructions will you give this patient?" If the resident's instructions are vague, you can point out the need to be more precise.

6. *Encourage and respond to questions from the patient.*

A patient may not ask questions for many reasons, such as fear of sounding foolish, or of wasting a physician's time. A patient's questions reveal the patient's concerns as well as the patient's misunderstandings about the diagnosis or the treatment plan. For example, a patient was referred to an orthopedic surgeon for a consultation by a family practice resident. When the resident asked, "What questions do you have?" the patient said, "Do I really have to have surgery?" The resident was able to reassure her that orthopedic surgeon is a name for a "bone specialist," and that she was not in danger of needing surgery. If the resident had not encouraged her to ask questions, she might have been sufficiently frightened of the prospect of surgery to drop out of treatment.

You can show a resident how to encourage a patient to ask questions or express concerns. "What else did you want to ask about today?" or "What questions do you have about the treatment plan?" or "What would you like to ask about your condition?" are a few examples of questions that you could ask when you see a patient with a resident.

7. *Assess the level of the patient's understanding about the condition and regimen by asking appropriate questions.*

Asking questions such as "What is your understanding of your condition?" or "Tell me what you are going to do for your sinus infection" is an excellent way of assessing a patient's understanding of the condition or the treatment plan. Further explanations can be given to the patient as needed.

When you see a patient with a resident, you can ask a patient questions like:

"When will you take your medication?"
"What will you do when you forget to take a pill?"
"How does a sinus infection affect your body?"
"What do you think caused your diabetes?"

Your questions will help the resident to learn how to assess the patient's understanding of the condition and the treatment plan. The responses will demonstrate the need for asking the questions.

When you discuss a patient with a resident, you can ask the resident questions such as:

"What does hypertension mean to this patient?"
"What does the patient believe to be the consequences of not following the treatment plan?"
"How long does this patient think the condition will last?"
"How long does this patient think s/he will need to follow a treatment plan?"

Questions like these help the resident to think about misconceptions a patient might have, and thus encourage the resident to assess a patient's understanding of a condition or a treatment plan.

8. *Summarize conclusions and instructions for the patient at the end of the visit.*

Summarization is a way of saying to the patient, "This is what has been said today which I believe is most important and what I want you to remember." A patient is more likely to remember important information the physician has clearly identified to be important.

When you consult with a resident about a regimen, you can ask the resident, "What recommendations have you already made to the patient?" or "What do you most want the patient to remember?" By answering, the resident practices summarizing this information. You can then suggest that the resident also summarize this information for the patient. When you see a patient with a resident, you can stress the importance of giving a summary to a patient; for example, "So, you have an infected hair follicle. The best thing to do is to apply warm wash cloths to the area. If it's not getting better in the next two days, or if it gets worse, come back and see me."

9. *Provide the patient with written instructions.*

A patient often remembers only a limited amount of what is said during a medical encounter. Forgotten or partially-remembered instructions result in nonadherence to medical treatment plans, and thus, poor medical outcomes. When discussing a treatment plan with a patient, you can make a brief note of any essential instructions and give these written instructions to the patient. The patient can take these written instructions home to use as a reminder of how to carry out the regimen. Some examples of written instructions are:

1. Salt water gargle
   (1/4 teaspoon salt in 1 cup lukewarm water 4 times a day.)

2. Take penicillin 4 times a day for 10 days until all pills gone.

3. Use ice packs, cold towels twice a day for comfort;
   No sports unless 100% pain free;
   Return in two weeks to clinic.

4. Avoid: caffeine, alcohol, smoking;
   Continue to use 1/2 teaspoon bentyl, 2 times a day for 2 months.
   Then use bentyl only when needed for pain.

5. Call Tuesday afternoon for results of potassium test;
   Keep feet elevated;
   Wear support stockings.

6. Continue salt water gargles;
   Fill prescription if culture positive (you'll be called);
   2 aspirin every 4 hours while awake;
   Drink at least 8 glasses fluid a day.

At the University of Wisconsin Family Practice Clinics, chart notes include a carbonless instruction sheet, one copy of which can be torn off and given to the patient. A second copy remains in the chart, thus providing both the patient and the physician with a written record of the treatment plan. In residencies that use these carbonless instruction sheets, you can easily comment on the presence or absence of patient instructions, when you review a resident's charts. In residencies that do not use these carbonless instruction sheets, you can suggest that a resident use written instructions.

APPENDIX 1

INSTRUCTIONS FOR THE OBSERVATION AND FEEDBACK PROCEDURE

Through the observation and feedback procedure, residents can be taught to integrate patient education skills into clinical practice. This is accomplished through the direct observation of a series of patient encounters for each resident. A trained observer uses a structured observation protocol to identify and record the patient education skills and deficits of each resident. After the series of encounters is over, verbal feedback is given for each encounter. Listing examples of resident statements and behavior, the observer praises the resident's skills and makes specific recommendations for improvement of those skills which the resident has not yet mastered. Later, residents are given a written summary of their feedback to keep as a record of observed skills and suggestions for improvement.

FORMAT OF OBSERVATION AND FEEDBACK PROCEDURE

Number of Encounters Observed

The observation and feedback activities described here specify that multiple patient encounters be observed for each resident. For each activity, a resident is observed during at least three patient encounters. Observations are scheduled for an entire clinic session; each resident is observed for an entire morning or afternoon.

One reason for observing multiple encounters for each resident is that the observer is able to assess a resident's patient education skills for a variety of clinical problems. You can easily make an inappropriate generalization about a resident's patient education skills on the basis of one observed encounter. After observing several encounters for each resident, you will be able to identify which tasks each resident regularly completes with a high level of skill. In addition, you are likely to find that residents will have a high level of skill at educating certain kinds of patients, such as pregnant women, or young children, and a low level of skill educating other kinds of patients, such as elderly persons or patients who are terminally ill. Observing several encounters will therefore increase your ability to identify each resident's skills and deficits.

In-room Observations

It is easiest to observe multiple encounters when the observer enters the examining room with the resident. It takes more time to arrange to use video recorders and one-way mirrors because of the necessary microphones and consent forms. But it is true that some patients will refuse to have an observer in the room. Equally, other patients might be concerned about the number of people behind a one-way mirror or the number of potential viewers of a videotape.

Additional time is required to observe a resident for multiple encounters through a one-way mirror. Unless more than one examining room is equipped with a one-way mirror and a microphone, the resident will have to wait for one patient to get dressed and leave before the next patient can be brought in.

Role of the Observer

For each encounter, the observer's role is to record specific examples of statements or behaviors of the resident that indicate the level of skill in performing the patient education criteria on the observation protocol. The observer also indicates whether or not a resident has performed the patient education tasks defined by those criteria. The information recorded on the observation protocol is used to develop educational feedback which is tailored to the individual needs of the resident. The ultimate role of the observer is to teach residents to educate patients. The observer does not interact with the patients s/he observes because the observer is in the examining room as a resident educator, not as a patient educator.

Scheduling of Feedback

Verbal feedback can be given either after each observed encounter or after a series of observed encounters. Another alternative is to schedule the feedback for another day. There are advantages and disadvantages for each option. (see Table 1). Most importantly, the observer and the resident decide according to their individual needs.

Written Feedback

The observer prepares a written version of the verbal feedback. The written feedback does not need to be lengthy or formal. The purpose is to document examples of the resident's skills and deficits as well as give suggestions for improvement which the observer has already discussed with the resident. A copy of the written feedback will help to encourage and facilitate the resident's efforts to increase her or his skills. The observer keeps a file copy of the feedback notes for each encounter along with the corresponding observation protocols, enabling the observer to monitor each resident's educational progress periodically. As the observation and feedback protocols contain specific examples of each resident's performance and the feedback given to each resident, other teachers in the residency may find these documents helpful in developing educational programs for continuing residents and for writing recommendations for graduating residents.

Preparation for Observation and Feedback Procedure

Before observing residents and giving feedback, the observer will find it helpful to be familiar with the clinical setting and experienced in the use of the observation protocol. The observer should also be in agreement with any other observers about the use of the protocol and the meaning of the criteria on the protocol. Practicing the use of the observation protocols will clarify the meaning of the criteria and highlight any difficulties the observer will have in using the protocol. A helpful suggestion is for the observer to go through an orientation of the observation and feedback procedure in order to become comfortable with the procedure and better able to respond to resident needs. If several individuals will be observing residents, a training session is useful to obtain agreement. A sample group training session is given in Appendix E. (See page 66).

PATIENT EDUCATION OBSERVATION FORM

ENCOUNTER INFORMATION

Physician ______________________
Observer ______________________
Patient ______________________

Date ______________________
Began __________ Ended __________
Patient Problem ______________________

BEHAVIOR CHECKLIST	Yes	No	N/A	EXAMPLES
A. Basic Communication & Assessment				
1. Did resident explore patient's concerns/reason(s) for visit?	___	___	___	
2. Did resident ask open-ended questions?	___	___	___	
3. Did resident ask about self-treatment prior to clinic visit?	___	___	___	
4. Were the effects of ongoing therapy monitored? (effectiveness/problems)	___	___	___	
5. Did resident use words patient could understand?	___	___	___	
6. Did resident tell patient what s/he was doing/examining?	___	___	___	
7. Did resident tell patient what s/he was finding?	___	___	___	
8. Were health promotion activities assessed and reinforced/encouraged (immunizations, diet, smoking, safety, breast self-exam)?	___	___	___	
B. Negotiation				
1. Did resident encourage/respond appropriately to patient questions?	___	___	___	
2. Did resident present information consistent with patient's needs (content/amount)?	___	___	___	
3. Did resident justify regimen to patient?	___	___	___	
4. Did resident prepare patient for symptoms/sensations?	___	___	___	
5. Were alternative treatment plans discussed with patient?	___	___	___	
C. Planning				
1. Was advice specific/concrete?	___	___	___	
2. Was patient provided with written instructions?	___	___	___	
3. Was patient asked to demonstrate understanding of plan (physically/verbally)?	___	___	___	
4. Were criteria or times set up for follow-up/call-in?	___	___	___	
5. Were supplemental referrals/resources used appropriately? (handouts, audio-visuals, other staff, commercial groups)	___	___	___	
6. Did resident repeat conclusions/instructions at end of visit?	___	___	___	

LIST INSTRUCTIONS OBSERVED:

Instructional Modules to Teach Primary Care Residents to Educate Patients, by
University of Wisconsin,
Department of Family Medicine and Practic
© 1981

THE OBSERVATION PROTOCOL

The observation protocol consists of four sections: They are The Encounter Information, The Behavior Checklist, The Instructions, and The Examples.

ENCOUNTER INFORMATION

The Encounter Information section enables the observer and the resident to recall the encounter. In order to safeguard privacy, only the patient's first name is recorded. The encounter information section is filled out as follows:

Physician:	Fill in the resident's full name.
Observer:	Fill in the observer's full name.
Patient:	1. Fill in the patient's first name only. The first name used in conjunction with the rest of the information which is recorded on the protocol should be sufficient to recall the encounter at a later time. 2 It may also be useful to fill in the patient's approximate age. The age helps the observer to identify possible patient needs; e.g., a three-month old baby has different health promotion needs than a 20-year-old woman.
Date:	Fill in the date that the observation takes place.
Began-Ended:	Fill in the times that the encounter begins and ends. This gives an idea of the length of the encounter, and provides some data for assessing a resident's efficiency in the use of time.
Patient Problem:	Fill in a concise description of the reason the patient came; e.g., "pap and pelvic," "well child care," "otitis media," "hypertension." If this is a follow-up visit, record f/u. This is important as it implies that some patient education may have taken place, and that the resident should assess ongoing therapy and compliance.

EXAMPLE:

PATIENT EDUCATION OBSERVATION PROTOCOL

ENCOUNTER INFORMATION

Physician John Smith
Observer Linda
Patient Jonah (3 months old)

Date 10-14-80
Began 10:29 Ended 10:45
Patient Problem Follow-up diarrhea

BEHAVIOR CHECKLIST

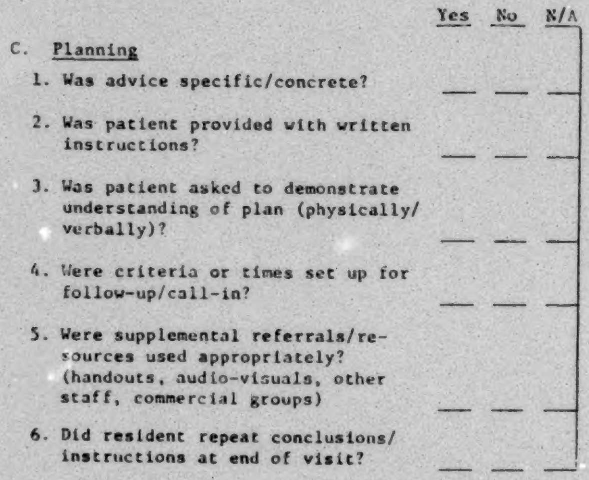
The Behavior Checklist consists of three groupings of criteria, each of which asks a question about a specific physician behavior, or set of behaviors. The checklist is organized to reflect the flow of the medical encounter. Questions about the history and physical examination are grouped in Section A, Basic Communication and Assessment:

BEHAVIOR CHECKLIST	Yes	No	N/A
A. Basic Communication & Assessment			
1. Did resident explore patient's concerns/reason(s) for visit?			
2. Did resident ask open-ended questions?			
3. Did resident ask about self-treatment prior to clinic visit?			
4. Were the effects of ongoing therapy monitored? (effectiveness/problems)			
5. Did resident use words patient could understand?			
6. Did resident tell patient what s/he was doing/examining?			
7. Did resident tell patient what s/he was finding?			
8. Were health promotion activities assessed and reinforced/encouraged (immunizations, diet, smoking, safety, breast self-exam)?			

Section B, Negotiation focuses on education about the patient's condition and treatment options:

	Yes	No	N/A
B. Negotiation			
1. Did resident encourage/respond appropriately to patient questions?			
2. Did resident present information consistent with patient's needs (content/amount)?			
3. Did resident justify regimen to patient?			
4. Did resident prepare patient for symptoms/sensations?			
5. Were alternative treatment plans discussed with patient?			

In Section C, Planning, specific criteria for a detailed behavior plan are listed:



C. Planning	Yes	No	N/A
1. Was advice specific/concrete?			
2. Was patient provided with written instructions?			
3. Was patient asked to demonstrate understanding of plan (physically/verbally)?			
4. Were criteria or times set up for follow-up/call-in?			
5. Were supplemental referrals/resources used appropriately? (handouts, audio-visuals, other staff, commercial groups)			
6. Did resident repeat conclusions/instructions at end of visit?			

Examples and discussion of each criteria can be found in the section of this Appendix entitled "Justification of Criteria," page 41.

After each criterion are three columns for checking Yes, No, or Not Applicable (N/A). The following examples illustrate the use of the checklist:

1. During a given encounter, a resident may primarily use words which the patient can understand: in this case, criterion A.5. is met, and the observer checks "Yes."

	Yes	No	N/A
A.5. Did resident use words patient could understand?	x		

2. Was patient provided with written instructions?
   If the patient is given written instructions, check "Yes" for criterion C.2. If the patient is not given written instructions, check "No." If the patient is not given any instructions at all, check "N/A."

3. In many instances "Yes" and "No" may both be checked. For example, during an encounter, a resident may tell the patient:
   > "Give her 1 teaspoon of the medicine three times a day for 10 days. Then we'll need to recheck her ear. If she's not better Saturday afternoon, give a call to the clinic. Give her fluids like water and seven-up even though she has diarrhea."

   The written instructions may say: "Make an appointment for next Tuesday."
   In a case like this, check both "Yes" and "No" for criterion C.2.

This indicates that written instructions are given for one part of the treatment plan and that written instructions are not given for another part of the treatment plan.

	Yes	No	N/A
C.2. Was patient provided with written instructions?	x	x	

4. Several of the criteria list more than one behavior. The behavior observed can be indicated by circling it on the protocol form. An example is criterion B.4.: Did resident prepare patient for symptoms/sensations?
If the resident tells the patient: "This speculum may feel a little cold," check "Yes" for criterion B.4., and circle the word "sensations."

	Yes	No	N/A
B.4. Did resident prepare patient for symptoms/[✓ sensations]?	x		

If, during the same encounter, the resident warns the patient:
"You may find that you feel very tired during the first trimester of your pregnancy,"
go back and circle the word symptoms for criterion B.4.

	Yes	No	N/A
B.4. Did resident prepare patient for [✓ symptoms]/[✓ sensations]?	x		

5. There are times when one or more of the criteria are not applicable to a particular encounter. The observer checks "N/A." For example, if no advice is given to a patient, the observer checks "N/A" for criterion C.1.

	Yes	No	N/A
C.1. Was advice specific/concrete?			x

The resident's progress at increasing patient education skills can easily be monitored when the resident is observed several times over a two- or three-year period, and all completed observation protocols are kept for each resident. Areas in which each resident needs to improve skills as well as areas in which they are skilled can be quickly identified by examining the behavioral checklist sections of each resident's observation protocols. The observation protocol is used during several different modules. For each observation, the observer completes the entire Behavior Checklist.

LIST INSTRUCTIONS OBSERVED

In the Instructions Section, located at the bottom left of the protocol, the observer notes any instructions that the resident gives the patient during an encounter. Physicians do not wait until the end of an encounter

TABLE 1

Advantages and Disadvantages of Times to Give Feedback

Times	Advantages	Disadvantages
During (between visits)	Enables resident to practice new skills and receive feedback. Uses "down-time" during clinic sessions. Cases fresh in minds of observer and resident.	Observer doesn't have opportunity to prepare feedback. May overburden resident's schedule of patient. Lack of time to discuss in detail.
At end of session	Cases fresh in minds of observer and resident. Observer may have time to prepare feedback. Observer can see patterns for entire clinic session.	May keep resident from writing notes. Observer may not have enough time to prepare feedback.
After written feedback prepared	Observer has had time to prepare detailed, well-organized feedback. Resident and observer can meet in relaxed atmosphere (lunch, coffee, etc.) Observer has time to check resources about questions in feedback.	Resident may forget salient points of cases. Observer may delay and forget details before writing feedback. Barriers to setting appointment may increase.

to give instructions to a patient; rather, they make suggestions throughout an encounter. When they summarize their instructions for a patient they often forget to include some of the things they have already told the patient to do. Since this can be extremely confusing for the patient as well as for the observer, it is essential that the observer write down each instruction when it is given.

LIST INSTRUCTIONS OBSERVED:

Go back to the same formula you were using, only half-strength. Go real easily. Start with 2 oz. 1/2 strength for 1st feeding. Go up to 4 oz. for the 2nd feeding, then to 6 oz. for the 3rd feeding. Tomorrow go to full strength.

We'd want to see him right away if:
1. *He showed signs of dehydration*
2. *Fever of 102 or greater*
3. *If he pulls at his ear*
4. *If he's vomiting.*

EXAMPLES

The Examples Section is used to record the specific statements and behaviors that illustrate the resident's skills or deficits at performing the criteria listed in the Behavior Checklist. The following examples demonstrate the use of this section:

1. The observer records statements which indicate that a resident has performed one of the criteria of the Behavior Checklist. Thus, if a resident tells the patient, "This speculum may feel a little cold," the observer writes down this statement in the Examples Section in addition to checking "Yes" for criterion B.4.

	Yes	No	N/A	Examples:
B.4. Did resident prepare patient for symptoms/ sensations?	x			*"This speculum may feel a little cold."*

2. The observer also records statements or behaviors which demonstrate that a resident has not performed one of the criteria on the Behavior Checklist. A resident might greet a patient with the comment," So you're just in for an earache, right?" The observer would check, "No" for criterion A.1., and jot down the resident's comment in the Examples Section:

	Yes	No	N/A	Examples:
A.1. Did resident explore patient's concern(s)/ reasons for visit?		x		*"So you're just in for an earache, right?"*

3. Notes about the physician's behavior are also recorded in the Examples Section. If a resident asks a patient, "Any questions?" while walking out the door of the examining room, the observer might check "No" for criterion B.1. and write "'Any questions?' while walking out the door":

		Yes	No	N/A	Examples:
B.1.	Did physician encourage/ respond appropriately to patient questions?		x		*"Any questions?" (while walking out the door).*

4. If, during one encounter, a resident were to ask open-ended questions part of the time and close-ended questions part of the time, the observer would list examples of each. This would explain why both Yes and No were checked for criterion A.2.

		Yes	No	N/A	Examples:
A.2.	Did resident ask open-ended questions?	x	x		*-"Was he on breast milk or formula until his last visit?"* *-"Has he been taking liquids?"* *-"Describe the stools."*

5. Examples are used to clarify those criteria which list more than one behavior:

		Yes	No	N/A	Examples:
A.6.	Did resident tell patient what s/he was doing/examining?	x	x		*"What I am going to do is hold him down." He gave no explanation of what he was examining.*

Because it is not possible to record every statement made during an encounter, examples are limited to the ones that are useful for feedback. The observation and feedback activities for Modules 1, 3, and 4 are designed to encourage the residents to practice the strategies in those modules. It is most important to record examples of resident statements and behaviors which are connected to the objectives of the module during which the observation takes place.

PATIENT EDUCATION OBSERVATION PROTOCOL

JUSTIFICATION OF CRITERIA

A. Basic Communication and Assessment

Criterion

A.1. Did resident explore patient's concerns/reason(s) for visit?

References

Platt and McMath (1979)
Enelow and Swisher (1979)

Rationale

Elicits patient's point of view, expectations and priorities which influence satisfaction and subsequent behavior.

Examples Meeting Criterion

1. "What brings you in today?"
2. "What concerns you the most?"
3. "What can I do for you?"

Examples Not Meeting Criterion

1. "So, let's have a look at that sore hand," or "You're here today for your back?"
   (Both questions focus the visit on a single problem and thus miss or ignore real patient concerns.)

Criterion

A.2. Did resident ask open-ended questions?

References

Platt and McMath (1970)
Enelow and Swisher (1979)

Rationale

Closed questions often elicit little or no useful information while open-ended questions can elicit accurate and useful medical information which the physician might not otherwise obtain (see examples).

Examples Meeting Criterion

1. "When do you notice the pain the most?"

2. "What makes it better. . . worse?"

3. "When have you been taking the medicine?"

Examples Not Meeting Criterion

1. "Is the pain sharp?. . . dull? etc."

2. "Are you taking the medicine?"

(Both of these questions restrict the kind and amount of information elicited. Question two can be answered affirmatively if any amount of medicine is taken.)

Criterion

A.3. Did resident ask about self-treatment prior to clinic visit?

References

Safer et al. (1979)
Williamson and Danaher (1978)
Leventhal (1975)

Rationale

Asking about prior self-treatment elicits:

1. Information about how disruptive the problem has been; e.g., home from work, changes, inactivity.
2. Ideas about patient's notion of what is wrong; e.g., antacids for heartburn that is actually heart attack.
3. Suggestions for treatment that the patient has already tried; e.g., bed rest, aspirin successfully or unsuccessfully.
4. Opportunities to reinforce appropriate home care:
    a. "I'm glad you didn't wait more than a week to see me about this blurry vision."
    b. "When you notice a lump in your breast (blood in the toilet) it's best to get it checked right away rather than waiting as long as you did."

Examples Meeting Criterion

1. "How have you treated this yourself?" - "What have you tried?" - "What helped...what made it worse?"
2. "How did you get the bleeding to stop?"
3. "What have you put on the rash to help the itching?" (This can tell the physician if something has exacerbated the rash, and what the patient has at home; e.g., calamine lotion, etc.)

Examples Not Meeting Criterion

1. "No questions?" (Ignores the patient's attempts to treat. Misses useful information.)
2. "You didn't try to treat this yourself, did you?" (Accusatory tone inhibits open answer.)

Criterion

A.4. Were the effects of ongoing therapy monitored? (effectiveness/problems)?

References

Sackett and Haynes (1976)
Meyer (1980)

Rationale

Patient's perception of treatment effects tells the physician how the patient is experiencing the treatment:

1. Medically, the outcome may be good but not according to the patient; e.g., the child's ears are better but child continues to be cranky, or blood pressure is down, but patient still feels jumpy.

2. Negative treatment effects can affect adherence: "treatment is making me worse, not better."

3. Subjective experience of the patient is important medical information for subsequent treatment adjustments and should be part of the treatment decision.

Examples Meeting Criterion

1. "How did the medicine affect the headaches?...worse?...better?...how much?"

2. "Did the medicine do what you expected? What did it do? What didn't it do?"

3. "Did you have any trouble with the medicines? Did they bother you in any way?"

Examples Not Meeting Criterion

1. No assessment -- (ignores patient input)

2. "No problems with the medicines?" - (implies none should exist)

3. "Well, that penicillin worked just great, didn't it?"

Criterion

A.5. Did resident use words patient could understand?

References

McKinlay (1974)
Svarstad and Lipton (1977)
Samora et al. (1961)
Ley (1977)

Rationale

Technical terms can confuse patients or intimidate them. In either case, communication is inhibited. Lay terms result in shared understanding of diagnosis and treatment.

Treatment instructions must be free of jargon; otherwise, patients will not be able to understand and follow them.

Examples Meeting Criterion

1. "The ear drum is less red and irritated than it was, but it's not quite back to normal."

2. "Take one of these thiazide (white) pills four times a day."

Examples Not Meeting Criterion

1. "The tympanic membrane looks a little dull," or "The belly is soft." (These common words to physicians carry special medical meaning unknown to patients.)

2. "The otitis media is resolving."

3. "Your glucose tolerance test was abnormal."

4. "Just take these PRN."

5. "Written instruction: 2 x q.i.d."

(Examples 2 through 5 clearly illustrate terms that can confuse or frighten patients.)

Criterion

A.6. Did resident tell patient what s/he was doing/examining.

References

Johnson (1972)
Skipper and Leonard (1968)
Leventhal and Johnson (1980)

Rationale

1. Patient has a right to know what the physician is doing and why. Withholding information controls the patient.

2. The patient can become anxious or angry, if s/he is unsure of reason for tests. ("Do they think it's cancer?" "Why is s/he concerned about my back if the pain is in my leg?")

3. The patient can assist in the examination if s/he knows what is being tested. (e.g., patient can question multiple laboratory tests if s/he knows what previous ones were for, or patient can anticipate painful parts and avoid flinching, etc.)

Examples Meeting Criterion

1. "First, I'll use the stethescope to find out how your breathing sounds, then to your heart to check that..."

2. "This hammer will test your reflexes...first your knees...then..."

3. "I'm going to use this little probe to get a sample of the discharge. The test in the lab will tell us if it's bacteria or something else..."

4. "This measures how well your ear drums are working during this infection. I'll put it up to your ear and we'll find out..."

(The above examples put the patient at ease and avoid the surprise or annoyance of scratching, hitting or other examination procedures.)

Examples Not Meeting Criterion

1. "Now we'll do the exam...mmm...mmm...everything's fine."

2. "Take off your clothes so I can check your chest."

3. "I'll definitely need a urine and blood sample today."

(The patient does not know what the physician is doing, or why.)

Criterion

A.7. Did resident tell patient what s/he was finding?

References

Svarstad and Lipton (1978)
Johnson (1972)

Rationale

First, patients have a right to basic medical information. Second, noncommunication can result in increased anxiety, distrust or misinterpretation of nonverbal cues. Sharing examination and test findings with the patient justifies treatment or nontreatment, and shows improvement or no improvement.

Examples Meeting Criterion

1. "The ear drum is less red today and will probably be fine if you continue taking the ____ as you have been, three times a day."

2. "Your belly feels a little hard to me which could mean:
   a. ______________
   b. ______________
   c. ______________

3. "Your blood pressure is 135/92 - putting that on your graph shows it's down some from last time, but it has a little way to go to get to the goal we set."

4. "Your baby weighs 19 pounds. Since he's seven months old, that puts him right here compared to others his age."

Examples Not Meeting Criterion

1. No statements during examination.

2. Statements such as: "Oh, my!" "Mmm", "That looks okay, I guess."

3. "Your blood pressure is okay."

(None of the above tells the patient what the physician is finding.)

Criterion

A.8. Were health promotion activities assessed, and reinforced/encouraged (immunizations, diet, smoking, safety, breast self-exam)?

References

Canadian Task Force Report (1980)
Society of Teachers of Family Medicine Task Force Report (1979)

Rationale

Preventive medicine is a cornerstone of primary care and can be incorporated into routine problem visits. Each visit is an opportunity to reinforce the health behaviors of the patient and to introduce new topics. Physicians can be potent influences in changing behavior; e.g., smoking.

Examples Meeting Criterion

1. "Now that he's here for his immunizations and he's about to start crawling around, don't forget that he has new dangers, too. Swallowing poisons is very common and there are a couple of things you can do...1. put things out of reach, 2. get syrup of ipecac... Here's a pamphlet that talks about these things.

2. "For a child this age, the greatest danger is accidents. Do you have a car seat?"

3. "Because you're having trouble with asthma, it probably would be a good idea to think about your smoking..."

Examples Not Meeting Criterion

1. No discussion of prevention...a lost opportunity.

B. Negotiation

Criterion

B.1. Did resident encourage/respond appropriately to patient questions?

References

Svarstad (1974)
Enelow and Swisher (1979)

Rationale

Shared understanding is necessary for informed decisions - patient's questions need to be encouraged and answered directly. Patients have a right to have questions answered.

If questions concerning understanding of instructions are not encouraged, mistakes can be inadvertently made. If the physician does not respond to questions of the patient, the patient may change physicians or drop out of treatment.

Examples Meeting Criterion

1. "I'm glad you asked that..."
2. "As it says in the handout I gave you..."
3. "I'll leave the room while you're getting dressed. Think about any questions you might have and ask them when I come back."

Examples Not Meeting Criterion

1. "No questions?" or "Any questions?(as resident is leaving room)." (These seem to imply that there should be none.)
2. "You don't need to know all that." (This seems to be an attempt to intimidate or control the patient.)
3. Strictly medical responses to questions: "That means a yeast infection." (This conveys little information.)
4. "Don't worry, the medicine will take care of it." (This seems to be a patronizing statement.)

Criterion

B.2. Did resident present information consistent with patient's needs (content/amount)?

References

Ley et al. (1973; 1976)

Rationale

Patients can absorb only so much information at one time. Try to assess information necessary for patient to make informed decision and to carry it out. If multiple problem visit; e.g., prenatal, well baby, chronic condition, plan to spend time on topics over several visits. The patient can also make a limited amount of major changes in lifestyle at one time.

Examples Meeting Criterion

1. "As we discussed last time, because your pressure is consistently high, we should begin treatment today. You'll start with a diuretic or water pill, which takes extra water from your system. You'll notice you'll go to the bathroom more often, etc. Take one pill every morning with breakfast. Here's a booklet telling you some more about high blood pressure and its treatment. In two weeks when you come back we can discuss other things in addition to the water pills that will help."

2. "Now that we know you are pregnant, you'll want some information about what it will be like and what to do. Here is a booklet of information on pregnancy and care. This covers the whole nine months, but I've put an asterisk by the parts that are most important to you right now. Next time you come in we can talk over anything you had trouble with."

(In both cases, the resident set priorities with the information, avoiding specifics of extraneous information, but preparing the patient for future topics.)

Examples Not Meeting Criterion

1. "We'll start you on the drug today. You should probably begin losing weight. I'll give you a diet that will tell you how much and what to eat and will also reduce your salt intake - you should quit salting your food at meal time. Take these pills which will work by taking sodium out of your body..."

2. "Now that we know you're pregnant, we should review diet, weight, delivery, and Lamaze classes. We also think you might have diabetes..."

(These illustrate too much information given.)

Criterion

B.3. Did resident justify regimen to patient?

References

Ley (1977)
Becker (1974)

Rationale

Simple assertions are inadequate. The patient has a right to know *why* treatment is necessary and/or desirable.

Patients are unlikely to follow advice if they do not understand the reason(s) for prescribed behavior. So many times a physician's goal does not coincide with a patient's goal of treatment. For this reason, the physician must justify the treatment plan. For example, instructions to "wait and see" can be interpreted as disinterestedness or neglect by a patient who is in pain and wants to alleviate symptoms immediately. The physician must explain that although s/he has the same goal, s/he must also verify the diagnosis in order to prescribe the proper treatment.

Examples Meeting Criterion

1. "You have strep throat; if you take one pill three times a day, this will begin to eliminate the infection. The coughing, etc., will probably go away in a couple of days, but it takes a full 10 days to kill the active infection. If you don't take them all, the strep is likely to come back."

2. "Salt in your food may be making treating your blood pressure more difficult. Salt tends to make your body retain water."

3. "Although steroid shots worked for you once, many times simply taking aspirin to reduce inflamed muscles and applying heat to relax them gets good results. How about trying that for a week and come in then if this isn't making it feel better?"

Examples Not Meeting Criterion

1. "Take these pills three times a day for your cold until all the pills are gone."

2. "Avoid salt."

3. "For your back pain take aspirin as needed, avoid lifting and apply heat."

(None of these supplies a reason for treatment.)

Criterion

B.4. Did resident prepare patient for symptoms/sensations?

References

Johnson and Leventhal (1980)
Meyer (1980)
Nerenz (1979)

Rationale

Anticipating typical symptoms and sensations of a disease and treatment process reduces anxiety caused by the unknown. It also tells the patient what is a normal part of the process and what requires prompt medical attention. Although some argue that side effect discussions suggest complaints, little data support this claim and withholding such information can foster dependence on the physician (phone calls, extra visits) to interpret all sensations or distress and dropping out because treatment caused extra problems beyond the condition itself.

Examples Meeting Criterion

1. "You're going to feel a little pin prick and then a warm feeling in your arm. That's the medicine going in."
2. "These pills should begin to make the blood pressure go down. You probably will notice that you go to the bathroom more often at first, especially within an hour or two of taking the pill, so take it at a time you know you'll be able to go later. Also, a few people notice dizziness the first few days. If this doesn't go away, or something else bothers you that you think might be related, call me at..."
3. "This probe will sting a little when I put it about a 1/2 inch up your penis, but that should go away in a minute or two."
4. "The D.P.T. shot will cause her arm to get a little red and she'll probably be cranky this evening. She may have a low fever (less than 106^{o}). If this doesn't go away within 48 hours, or you notice something else, call me at..."

Examples Not Meeting Criterion

1. "Oh, I bet that hurt."
2. "These pills will do the trick for your blood pressure."
3. "I'm going to stick this probe in your penis."
4. "Here's the child's D.P.T."

(These examples do not demonstrate concern for the patient and invite anger or anxiety.)

Criterion

B.5. Were alternative treatment plans discussed with patient?

References

Shulman (1979)
Swain (1980)
Fink (1976)

Rationale

The patient's preferences must be taken into account whenever possible, (1) to insure patient's commitment to plan, (2) to make plan workable in the patient's context, (3) to educate the patient in the causes and treatment of the disease process s/he is experiencing. The alternatives need discussion because the patients will often alter the plan to fit themselves (possibly inappropriately) if such discussion does not take place.

Examples Meeting Criterion

1. "As you know, there are several methods of birth control. We have some handouts which describe the pluses and minuses of each. Next time we can talk about them. I encourage the patients I see to use a method like the diaphragm because..."

2. "High blood pressure can be controlled in several ways. Sometimes, simply losing weight will bring it down. A low salt diet might also work. Adding exercise to this often reduces slightly elevated blood pressure, or we have some medicine which is effective in lowering blood pressure, but you'll need to take it every day, probably indefinitely. Where would you like to start?"

3. "I can either give some pills to clear up the vaginal discharge, or often a vinegar or yogurt douche works. Which would you like to try?"

Examples Not Meeting Criterion

1. "I think you should use the diaphragm for birth control."

2. "Take two pills twice a day for your blood pressure."

3. "Take this pill twice a day for ten days for vaginal infection."

(For each case, the physician has chosen a plan without discussion of options.)

C. Planning

Criterion

C.1. Was advice specific/concrete?

References

Ley (1969), (1977)

Rationale

Vague recommendations can be widely interpreted. Also, patients can become extremely frustrated with vague instructions, and believe that, "The doctor doesn't know what s/he's talking about," "I can't/won't do that," "S/he doesn't care. S/he just wants money," "S/he doesn't even tell me how to do that."

Examples Meeting Criterion

1. "Only walk on the foot to go between the bed and the bathroom - have someone else cook your meals, then see me on Wednesday, and if the swelling is down by Wednesday, you can start doing ___________."
2. "Besides what you're feeding now, give him 3 ounces of formula each time. If he hasn't gained ____ ounces by next ____ we'll try ____."

Examples Not Meeting Criterion

1. "Take it easy with that foot." (This can mean miss work, skip soccer, etc.)
2. "Feed the baby more often." (How much? How often?)
3. "Stop smoking."
4. "Lose weight."

Criterion

C.2. Was patient provided with written instructions?

References

Svarstad (1976)
Crichton, Smith and Demanuele (1978)

Rationale

Written instructions can be taken home. They act as a reminder, and they stress the importance of instructions. (In our setting instructions are written on a carbonless sheet that produces a copy so that there is a record of what the plan is for both patient and physician.

Examples Meeting Criterion

1. "Hydrochlorothiazide 25 mg's, take two tablets after each meal (that is, three times a day.)
    a. "You might notice..."
    b. "Call if you notice..."
    c. "Come to clinic on _____ at _____."
2. a. "Do Williams' Exercises (see booklet) when you get up and when you go to bed."
    b. Use heating pad at night (low setting) to relieve pain."
    c. "If it feels progressively worse over the next five days, call me Monday at 12:30."
    d. "Come in for follow-up September 29, 1980, at 2:30 p.m."

Examples Not Meeting Criterion

1. No written instructions.
2. "Do exercises twice a day."
3. "RTC - two weeks."
4. "Take it easy next seven days."

(A vague or technically-written instruction is not very useful either.)

Criterion

C.3. Was patient asked to demonstrate understanding of plan (physically/verbally)?

References

Leventhal, Singer and Jones (1965)
Fink (1976)

Rationale

Patients are often confused by a plan and are unsure if they can carry it out. Physical or verbal rehearsal demonstrate to the patient that the plan is workable ("I can do the exercises"). It also points out problems ("Am I doing this right?") and anticipates difficulties ("Should this hurt?") which can be corrected or reinforced following the rehearsal.

Examples Meeting Criterion

1. "Here are two exercises. Feel this muscle tighten when you flex your leg? That should happen each time - now you try it. No, not so tight that it hurts!, etc."

2. "Show me how you would do a breast self-examination." (The patient gets immediate feedback on how well she is doing the exam.)

3. "Now, you'll need to get these shots. Do you know how to get to the City-County Building? Is there a day/time you'll be able to go?"

Examples Not Meeting Criterion

1. "Follow the exercises in the book." (Some of the exercises may be inappropriate for this patient.)

2. "Now that I showed you how to do a breast self-exam, do it once a month." (The physician has no idea how well the patient has learned.)

3. "Get these shots at the City-County Building."

Criterion

C.4. Were criteria or times set up for follow-up/call in?

References

Johnson et al. (1965)

Rationale

When left purely to discretion, follow-up can be very problematic. Examples:

1. Patients may wait too long or not return since they've already been in;
2. Patients may call late at night for reassurance about something that needed attention earlier;
3. Patients may be expecting quick recovery, which can be uncovered and corrected by setting an appointment or call-in date;
4. Setting some bounds for the recovery period gives the patient a time period in which to notice treatment progress.

Examples Meeting Criterion

1. "When do you think you should come in again?" (This gives the patient a chance to express ideas about course of treatment.)
2. "If the back doesn't start to get better in one week, call me between 4:00 p.m. and 6:00 p.m. next Thursday. If it's doing better, come for the appointment that we'll set for two weeks from today."

Examples Not Meeting Criterion

1. "See me in three months for your diabetes."
2. "Come for recheck in two weeks for back pain."

(Neither of these examples provides the patient with criteria for evaluating success or problems with treatment or really justifies a repeat visit.)

Criterion

C.5. Were supplemental referrals/resources used appropriately? (handouts, audiovisuals, other staff, commercial groups)?

References

Society of Teachers of Family Medicine Task Force Report (1979)

Rationale

Written and audiovisual aids can introduce new material, reinforce explanations and instructions, and anticipate typical problems in home care (stitches, cast care, etc.) Primary care physicians must also be prepared to make referrals to other staff (counseling, nursing, dietary) and to community resources to make optimal use of their own and other's time.

Examples Meeting Criterion

1. "While we're waiting for the lab results, why don't you watch this movie on high blood pressure? You can ask me questions about it when we talk about the lab results."

2. "Here's a big packet on prenatal care. I'll place an asterisk by the things you'll need to know right now. We can discuss any questions or problems at the next visit."

3. "If you're interested in losing weight, we have a nurse specialist on our team who can talk about some specific changes with you and/or give you a list of community resources. Would you like to meet her?"

Examples Not Meeting Criterion

1. "Here's a movie on high blood pressure. It'll tell you all you need to know."

2. "Here's a packet on prenatal care."

3. "You should lose some weight."

Criterion

C.6. Did resident repeat conclusions/instructions at end of visit?

References

Bradshaw et al. (1975)
Ley (1977)

Rationale

Retention of instructions is difficult. This repeat will stress the importance of instructions and can be an opportunity to make sure that physician and patient have a shared understanding of the treatment plan.

Examples Meeting Criterion

1. "Here's a copy of the plan we decided on: first, don't lift heavy objects (get someone else to do it); second, begin exercises tomorrow morning; third; etc."
2. "We could only cover the diabetes problem today. This is how to get that back under control: 1. ... 2. ..." "If things are going better, the next time we can start to discuss the stresses you're feeling at work and some ways to deal with them."

Examples Not Meeting Criterion

1. No repetition.
2. "Well, that should clear up the problem."
3. "Any questions?" (as physician leaves the room)

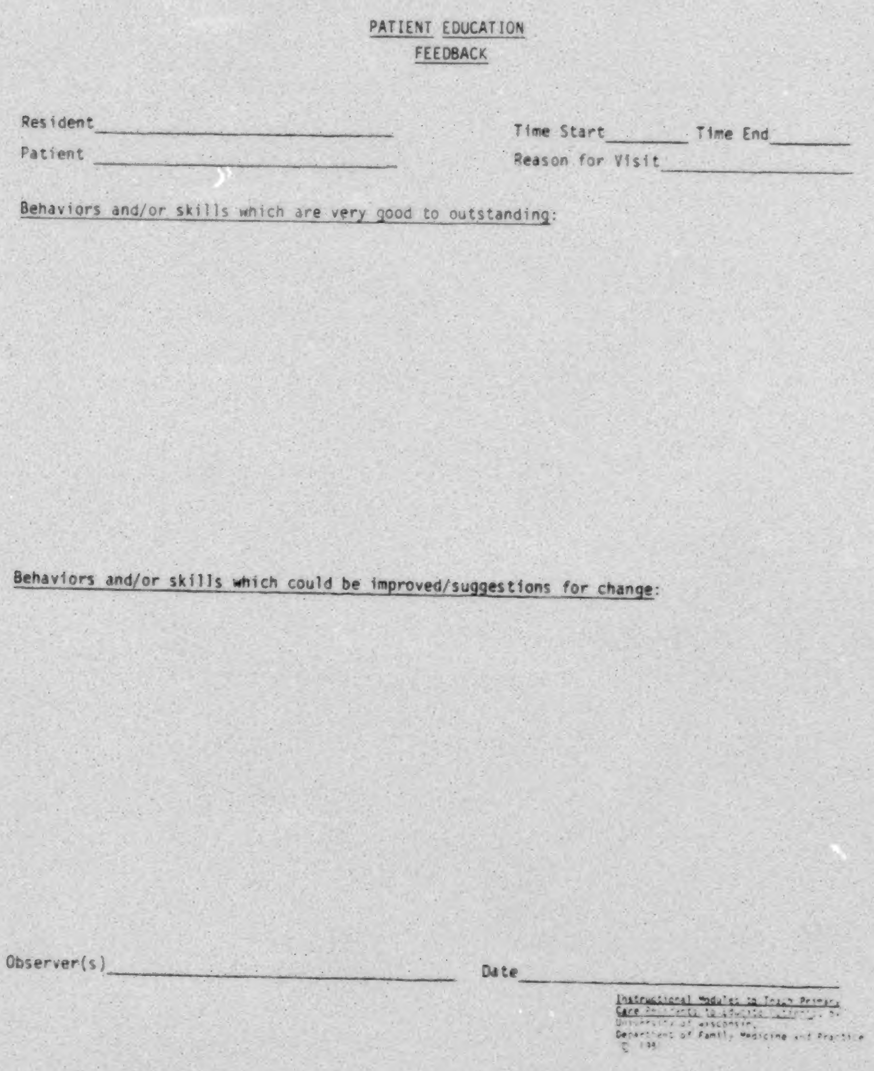
(All three of these fail to take advantage of the opportunity to repeat the plan.)

INSTRUCTIONS FOR GIVING FEEDBACK

Using a process developed by Sternburg and Brockway (1979), the observer gives each resident verbal and written feedback for each encounter observed. The observer first comments on the skills of the resident, and then cites areas in which the resident could improve. In order to avoid presenting a resident with more suggestions than s/he can use, the observer does not cover all of the criteria on the observation protocol at any one time. Rather, the focus of feedback for each encounter is limited to the criteria on the observation protocol that reflect the topic of the module during which the observation and feedback activity occurs. By concentrating on a select group of criteria, the observer is able to provide in-depth feedback to each resident.

Written Feedback

A simple form is used for preparing written feedback:



PATIENT EDUCATION
FEEDBACK

Resident________________________ Time Start________ Time End________
Patient________________________ Reason for Visit________________

Behaviors and/or skills which are very good to outstanding:

Behaviors and/or skills which could be improved/suggestions for change:

Observer(s)________________________ Date________________________

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Feedback Protocol

At the top of the form, basic information about the visit is recorded.

PATIENT EDUCATION
FEEDBACK

Resident____________________________ Time Start________ Time End________

Patient ____________________________ Reason for Visit__________________

Information about the time the encounter starts and ends gives an idea of the length of the encounter. This is an indication of the ability of the resident to use time efficiently. The name of the patient and the reason for the visit (e.g., well-child care, earache, hypertension follow-up) are recorded identifying to which encounter the feedback pertains.

The remainder of the form contains two sections:

1. Behaviors and skills which are very good to outstanding.

2. Behaviors and skills which could be improved/suggestions for change.

These sections divide feedback into comments on areas of skill and areas that need improvement.

There are several reasons for giving positive feedback. It is important for the observer to be aware of and to keep a record of a resident's skills as well as a resident's deficits. Educational plans build on strengths in order to correct weaknesses. An example illustrates this:

> 1. *You asked some open-ended questions of the mother, which provided you with useful information. "Why don't you fill me in?" "Describe the stools." "How has he seemed otherwise?" These questions also allowed the mother an opportunity to tell you what concerned her about her child. At other times you asked: "He's over his cold now?" The mother said, "Yes..." You might have gotten more information about him if you'd asked: "How is his cold now?"*

Another reason for giving positive feedback is to identify for a resident what the observer believes to be a skill and to encourage the resident to continue to practice the skill by discussing its utility and value.

Preparing Written Feedback

It is important to prepare written feedback as soon as possible after observing a series of resident-patient encounters. This will enable you to make precise and detailed comments. Fill out a separate feedback form for each encounter. Referring to the observation protocol, select specific examples of a resident's statements and behavior for comment. Use examples drawn from the criteria that correspond to the objectives of the module during which the observation takes place. It is important to note that it is not necessary, nor even desirable, to comment on each of these criteria.

Rather, use for feedback those examples of each resident's performance that indicate either a high level of skill and/or those which indicate need for improvement.

Feedback Format

For each skill you give feedback on:

1. Describe the resident's behavior;

   "You asked good open-ended questions."

2. List a specific example of the behavior, preferably a direct quote from the encounter;

   "What has helped the pain?"

3. Comment on the importance and the outcome of the behavior;

   "You get more specific, accurate, and useful information with this kind of question."

For each deficit you give feedback on:

1. Describe the resident's behavior;

   "You used several technical words and phrases."

2. List a specific example of the behavior, preferably a direct quote from the encounter;

   "This will suppress inflammation," or

   "I'm testing your visual fields."

3. Comment on the importance and outcome of the behavior;

   "I don't think that this 15-year-old boy could understand what you were saying."

4. Give a specific suggestion for improvement;

   "This should make the swelling go down."

   "I'm testing your eyes to find out how much you can see at one time, or how big an area your eyes can see at once."

The following are samples of an observation protocol and a feedback form for an encounter that was observed in Module One: (Notice that each comment on the feedback form follows the format discussed above.)

PATIENT EDUCATION OBSERVATION FORM

ENCOUNTER INFORMATION

Physician John Smith
Observer LMV
Patient Jonah (3 months old)

Date 10/14/80
Began 10:29 Ended 10:38
Patient Problem follow-up diarrhea

BEHAVIOR CHECKLIST	Yes	No	N/A	EXAMPLES
A. Basic Communication & Assessment				
1. Did resident explore patient's concerns/reason(s) for visit?	x			I've just read Dr. Jones' note from your visit four days ago. Why don't you fill me in?
2. Did resident ask open-ended questions?	x &	x		Describe the stools? Has he been taking liquids? Has he been eating?
3. Did resident ask about self-treatment prior to clinic visit?	x			Have you been giving him anything else? Was he on breast milk or formula until the last visit?
4. Were the effects of ongoing therapy monitored? ([✓ effectiveness]/ problems)	x			How has he seemed otherwise? He's over his cold now?
5. Did resident use words patient could understand?	x			Has he been pulling on his ear? What I am going to do now is hold him down.
6. Did resident tell patient what s/he was ([✓ doing]/[✓ examining])?	x &	x		His throat looks red, so I'm going to get a throat culture to make sure that he doesn't have strep.
7. Did resident tell patient what s/he was finding?	x			There is no sign of bacterial infection in his ear.
8. Were health promotion activities assessed and reinforced/encouraged (immunizations, diet, smoking, safety, breast self-exam)?		x		He doesn't look dehydrated: he has good tears, his skin bounces back when you touch it, and it doesn't feel dry; his tongue's moist. So he is taking in enough liquid to make up for what is going out.
B. Negotiation				
1. Did resident encourage/respond appropriately to patient questions?	x			
2. Did resident present information consistent with patient's needs (content/amount)?	x			I'm going to stick this swab in his rectal area... I'm going to make a slide of this to make sure that he doesn't have a bacterial infection which we would treat with antibiotics.
3. Did resident justify regimen to patient?	x			
4. Did resident prepare patient for symptoms/sensations?		x		
5. Were alternative treatment plans discussed with patient?		x		
C. Planning				
1. Was advice specific/concrete?	x			*Do you know what signs of dehydration are? (The mother repeated them back)
2. Was patient provided with written instructions?	x			
3. Was patient asked to demonstrate understanding of plan (physically/[✓ verbally]) signs of dehydration	x			
4. Were criteria or times set up for follow-up/call-in?	x			The mother asked several questions about what half strength meant. She seemed confused.
5. Were supplemental referrals/resources used appropriately? (handouts, audio-visuals, other staff, commercial groups)		x		
6. Did resident repeat conclusions/instructions at end of visit?	x			

LIST INSTRUCTIONS OBSERVED:

Go back to the same formula you were using, only half strength. Go real easy. Start with 2 oz. half strength for the 1st feeding. Go up to 4 oz. for the second feeding, then to 6 oz. for the third feeding. Tomorrow go to full strength. We'd want to see him right away if:
(1) he showed signs of dehydration*
(2) fever of 102 or greater
(3) if he pulls at his ear, (4) if he's vomiting

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PATIENT EDUCATION
FEEDBACK

Resident *John Smith*

Patient *Jonah (3 months old)*

Time Start *10:29* Time End *10:45*

Reason for Visit *follow-up, diarrhea*

Behaviors and/or skills which are very good to outstanding:

1. *You asked some open-ended questions of the mother, which provided you with useful information. "Why don't you fill me in?" "Describe the stools." "How has he seemed otherwise?" These questions also allowed the mother an opportunity to tell you what concerned her about her child. At other times you asked: "He's over his cold now?" The mother said, "Yes..." You might have gotten more information about him if you'd asked: "How is his cold now?"*

2. *You told the mother what you were examining and why: "I'm going to stick this swab in his rectal area...I'm going to make a slide of this to make sure he doesn't have a bacterial infection which we would treat with antibiotics." Explaining what you are doing may reduce the patient's anxiety by limiting his imagined reasons for your behavior.*

3. *You told the mother what you were finding: "There is no sign of bacterial infection in his ear; he doesn't look dehydrated; he has good tears...his tongue is moist, so he is taking in enough liquid to make up for what is going out." You effectively provided the mother with an opportunity to learn how to begin to rule out dehydration.*

4. *You gave the mother written instructions. This is an excellent thing to do; it provides a memory aid which enables patients to carry out the regimen. Many people forget instructions, or the specifics of instructions after they leave the doctor's office.*

Behaviors and/or skills which could be improved/suggestions for change:

1. *When you gave the mother instructions about feeding, you said: "Go back to the same formula you were using, only half strength. Go real easy. Start with 2 oz. half strength for the first feeding. Go up to 4 oz. for the second feeding, then to 6 oz. for the third feeding. Tomorrow go to full strength."*

   The mother asked a lot of questions about what full strength meant. She clearly didn't understand what you meant. You might have said: "Prepare the baby's formula as you usually would. Then, for the first feeding, mix one ounce of the prepared formula with one ounce of water. For the second feeding, mix 2 ounces of prepared formula with 2 ounces of water...Tomorrow, use the formula the way you usually would. You don't have to mix it with water tomorrow."

Observer(s) *Linda*

Date *10/4/80*

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During this encounter, a mother brought her three-month-old son, Jonah, back to the clinic to see Dr. John Smith, a second-year resident. Jonah and his mother had been in to see Dr. Smith four days previously for the same problem, diarrhea. Dr. Smith began the encounter by asking open-ended questions. Dr. Smith also asked a series of questions which called for a "yes" or "no" answer.

"Resident will use open-ended questions throughout the visit," is a Module 1 objective. Because of this, Linda, the observer, recorded quotes of both kinds of questions under "Examples" on the observation protocol. For the same reason, Linda recorded what Dr. Smith said when he told the mother what he was doing and finding when he examined Jonah. Dr. Smith justified the regimen he suggested and provided written instructions and criteria for the mother to use if her son got worse. Although he assessed the mother's understanding of dehydration, he failed to assess whether she understood his instructions for preparing Jonah's formula.

Although the observer filled out the entire Behavior Checklist, she did not give feedback on every criterion. Rather, the written feedback for this encounter identified five specific examples for discussion. These feedback comments all pertained to observation protocol criteria which reflect the Module 1 objectives.

For each comment, the observer:

1. Described the resident's behavior in terms of a patient education strategy;

2. Gave at least one specific example of what the resident said or did during the encounter; and

3. Stressed the importance or outcome of the behavior.

For the fourth comment, which addressed one of the resident's deficits, the observer also gave a specific suggestion for improvement.

The observer could have included more comments about the resident's choice of words, or of the resident's excellent use of a question to assess the mother's knowledge of the signs of dehydration. However, she chose to limit the amount of feedback she presented. The observer justified her assertion that the resident's instructions for formula preparation were not sufficiently clear by citing the number of questions the mother asked. It is important to avoid value judgements such as, "You did a poor job giving the mother instructions." Value judgements are likely to produce a negative reaction from a resident and thus close off an educational opportunity.

Verbal Feedback

The same guidelines that have been given for the format of written feedback apply to verbal feedback. Using the written feedback form as a memory aid, discuss selected aspects of each encounter with a resident, first citing instances in which the resident demonstrated skill, and then instances which indicated a need for improvement for each comment:

1. Describe the behavior you wish to discuss;

   "You asked questions which only call for a yes or no answer.

   'So, did you take it easy on Sunday?'"

2. Stress the importance and/or outcome of the behavior;

   "The patient is likely to answer 'yes,' as she did, even though she might not have taken it easy. As the concept, 'take it easy' is open to wide interpretation, you really didn't get any useful information."

3. Give a specific suggestion for change, if appropriate;

   "You could ask her: 'Describe what you did on Sunday.' This is likely to produce more detailed and accurate information."

GROUP TRAINING SESSION FOR THE OBSERVATION AND FEEDBACK PROCEDURE

Preparation for Observers

Before the training session takes place, distribute copies of "The Observation and Feedback Procedure" to each observer who will be trained. Ask observers to read these materials carefully and to bring the pamphlet to the training session.

INSTRUCTIONS FOR GROUP TRAINING SESSION

I. Introduction

  A. Put a transparency of the Observation Protocol on an overhead projector.

  B. Briefly describe the use of the Observation Protocol.

II. Practice Using Observation Protocol for a Resident-Patient Encounter.

  A. Observe a resident-patient encounter with the group. Two ways of doing this are:

    1. Observe a videotaped encounter.

    2. After obtaining permission from the resident and patient to be observed, watch a clinic encounter through a one-way mirror in your residency's outpatient clinic.

  B. Ask each observer to fill out an observation protocol while the encounter takes place, using the Observation and Feedback Procedure instructions.

III. Group Discussion of Encounter Observed

- A. Put a transparency of a blank observation protocol on an overhead projector.
- B. Ask the group to decide how each criterion should be checked for the encounter that was just observed.
    - 1. Ask group members to justify their answers for each criterion by citing specific quotes or behaviors from the encounter. Record these and examples on the observation protocol.
- C. Identify group differences of opinion concerning some of the following points:
    - 1. Definition of terms (self-treatment, not applicable, etc.)
    - 2. When to check Yes, No, N/A
    - 3. How to choose which example to record.
- D. Through discussion establish group consensus on these issues:
    - 1. Group can decide on a definition of any terms which are in dispute.
    - 2. We suggest that decisions regarding when to mark Yes, No, N/A be left up to each individual observer so long as s/he is careful to record specific examples of statements or behaviors which explain her/his decision.
    - 3. The group can decide whether or not to:
        - a. Record examples for as many criteria as possible
        - b. Only record examples for the criteria that correspond to the objectives of the module during which the observation takes place.

IV. Briefly Summarize Instructions for Writing Feedback

V. Ask Each Member of the Group to Fill Out Feedback Protocols for the Encounter Just Observed, Referring to the Observation Protocol Completed by the Group.

VI. Divide Group Members into Pairs, and Ask Them to Role Play Giving Verbal Feedback, using the Written Feedback they have just Prepared. Give each Group Member the Opportunity to Assume the Roles of Patient and Resident.

Timetable

The amount of time needed for this session varies according to the of participants. The following time allotments should suffice for three or four participants:

1. Observation of resident-patient encounter: 20-30 minutes.
2. Group discussion of observation protocol: 30 minutes - 1 hour.
3. Preparation of written feedback: 10-20 minutes.
4. Role plays of feedback procedure: 30 minutes - 1 hour.

Total time needed: 1-1/2 to 3 hours.

Instructional Modules to Teach
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MODULE 2

PSYCHOSOCIAL FACTORS IN PATIENT EDUCATION: HOW PATIENTS THINK ABOUT ILLNESS

MODULE 2

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INTRODUCTION

A wide range of factors influence a patient's reaction to illness and treatment. Outpatient care, in contrast to inpatient care, depends upon the patient deciding to seek treatment and to follow through with recommendations. The first step for the primary care resident is to appreciate the active role the patient has in this process, even though s/he may appear to be a passive recipient of medical care during the medical encounter. Module 2 is designed to give primary care residents:

1. An appreciation for the patient's perspective on illness and treatment;

2. A framework within which to assess the patient's perspective on her or his illness;

3. Examples of ways to individualize the doctor-patient encounter using this assessment.

The resident's assessment of the patient's perspective on her or his illness depends on expertise in applying the basic communication skills taught in Module 1.

Two seminars explore the patient's perspective on illness and treatment. The first seminar presents the simple "common-sense" process that patients use to make sense of symptoms, illness and treatment. The common experience of a headache is explored by the seminar group, showing how different past experience with headaches can lead to different self-treatments and help-seeking. The residents discuss personal symptom experiences that demonstrate the process of deciding what the symptom means and what to do about it.

The second seminar uses the same common-sense framework to explore the patient's and physician's reactions to difficult-to-diagnose problems. Using examples of a physician's reactions to his own heart disease and treatment taken from Martha Lear's book Heartsounds, the thoughts and feelings of patient's with complex problems are discussed. Finally, suggestions are made on questions to ask patients to assess how the individual is making sense of and coping with her/his condition.

Individual resident activities which address skills in assessing the patient's perspective on illness and treatment are deferred until Modules 3, 4 and 5, where that assessment is an important factor in developing diagnostic treatment plans.

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OBJECTIVES FOR MODULE 2

Residents will demonstrate an ability to:

1. Interview patients in a manner which facilitates patient reporting of symptoms;
2. Assess patients' beliefs and thoughts about etiology/meaning of problem;
3. Assess actions the patient has taken to verify the etiology of symptoms or to relieve symptoms;
4. Assess patients' beliefs and thoughts about their symptoms/conditions;
5. Assess the symptom or side effect experiences of patients with long-term problems.

DISCUSSION OF MODULE 2 OBJECTIVES

1. *Residents will interview patients in a manner which facilitates patient reporting of symptoms.*

   A fundamental skill in medical interviewing is to gather accurate reports of the patient's symptom experience. (Enelow and Swisher, 1979). Symptoms are often difficult to describe accurately (Leventhal, 1975), and a patient may be hesitant to report symptoms s/he does not perceive to be directly related to the presenting complaint. Eagerness to fit a set of symptoms to a diagnosis can cause the resident to miss important medical information.

2. *Residents will assess patients' beliefs and thoughts about etiology/meaning of problem.*

   A patient's beliefs and thoughts about the problem have important effects on behavior in response to the problem (Becker, 1974; Meyer, 1980; Leventhal, 1975). Assessment of these perceptions by the physician can identify areas of need for patient education so that the patient and physician have a shared understanding of the problem and its treatment.

3. *Residents will assess actions the patient has taken to verify the etiology of symptoms or to relieve symptoms.*

   Before consulting a physician, the patient actively attempts to figure out the cause of the symptoms and to relieve them (Leventhal, 1975; Williamson and Danaher, 1978). Assessing the steps the patient has already taken has two important benefits. First, this assessment can provide medical information about the disease and possible treatment; for example, aspirin and rest have not relieved this symptom. Second, the assessment creates an opportunity to reinforce proper home management, or to correct inappropriate home remedies.

4. *Residents will assess patients' beliefs and thoughts about their symptoms/conditions.*

   Symptoms and diagnoses can have idiosyncratic meaning for a patient (Svarstad and Lipton, 1977). Because such meanings may be incorrect or lead to inappropriate treatment, they must be assessed. The assessment provides opportunities for educating the patient about her or his body and caring for it.

5. *Residents will assess the symptom or side effect experiences of patients with long-term problems.*

   Long-term problems require careful assessment of the experiences of the patient. Symptom and side effect experiences can lead the patient to alter medications or drop out of treatment (Meyer, 1980). These assessments communicate the physician's concern for the patient and the patient's perceptions of how the treatment is progressing. An assessment of these experiences can also uncover important complications that need attention. Often, regimens can be altered to minimize side effects due to treatment.

SEMINAR FOR MODULE 2

HOW PATIENTS THINK ABOUT ILLNESS

PART I: Making Sense of a Symptom

The goals of this seminar are to:

1. Provide the resident with an understanding of how people think about and deal with disease and treatment.

2. Demonstrate how an assessment of an individual's perspective on her or his illness can provide the resident with guidelines for the kinds of information to include when explaining diagnoses and plans to the individual.

A short introduction diagrams a "common sense" approach to illness and treatment and each resident then uses this diagram to outline a recent personal illness (or symptom) experience. Presentation and discussion of each resident's experience demonstrates both the common features and the individual differences that necessitate assessment of the patient's perspective on her or his condition. Finally, methods of assessing and incorporating the patient's perspective into the diagnostic and treatment plans are presented and discussed.

OBJECTIVES

The resident will demonstrate an ability to:

1. Describe a personal symptom/illness experience, listing its sensations, all the potential explanations for the experience that s/he considered, and the process of deciding on some final explanation for it;

2. Facilitate the patient reporting of symptoms;

3. Assess the patient's beliefs/thoughts about etiology of problem;

4. Assess actions the patient has taken to verify etiology or to relieve symptoms.

PREPARATION OF THE SEMINAR LEADER

The leader should become familiar with a "common sense" approach to understanding illness conditions by reading Seminars 1 and 2 and "The Role of the Clinical Faculty" section of this module. The leader should be comfortable with group discussion. The "Discussion of Objectives" section provides a brief review of the research literature relevant to this seminar. Dr. Lloyd's "My Style in Family Practice" in Appendix II and the summary narrative at the end of this seminar are important further sources. Much of the seminar material has been developed from careful readings of Leventhal's (1975) chapter entitled, "The Consequences of Depersonalization during Illness and Treatment." Readers interested in a more detailed discussion may wish to read that chapter.

The presence of one or more staffing physicians or nurses provides a fruitful source of good clinical examples.

PREPARATION OF THE RESIDENTS

Read Lloyd's "My Style in Family Practice" (page 104). Residents interested in further reading should be referred to the "Discussion of Objectives" and "Role of the Clinical Faculty" sections of this module, or to the Handout to Part I in Appendix I (page 99).

SEMINAR OUTLINE

I. Introduction

Today's seminar is designed to give the resident an appreciation of the patient's perspective on disease and treatment. Since experience is the best teacher, the authors considered giving each resident a painful symptom, such as food poisoning or a broken leg, but minor logistical and ethical problems made this impossible. Therefore, each resident should spend the first five minutes of the seminar writing about some symptom or problem s/he personally experienced that really was of concern. Toward the end of the seminar some of the patient education issues that are raised by the residents' examples will be discussed. Take five minutes and write on the transparency (page 80).

1. What the symptom problem felt like with as much detail as you can.
2. What you thought it was or might be.
3. How you decided:
   a. What it really was.
   b. How to handle it.

If a resident can't think of one, use medical school experience of the medical student's syndrome. (Give each resident the transparency "Recent Symptom of Concern" and a grease pencil.)

II. Why is the patient's perspective or point of view important?

A. People deal with a broad spectrum of symptoms/problems on their own and only a small proportion consult physicians (Williamson and Danaher, 1978). Cite examples from the following table:

Percent of People Experiencing Symptoms in a Two-Week Period		Proportion of People Consulting Physicians
	%	
Worry, depression	21	less than 1/2
Headaches	38	less than 1/2
Tiredness	16	less than 1/2
Constipation	10	less than 1/2
Cough	32	between 1/2 and 2/3
Weight problems	10	between 1/2 and 2/3
Sore throat	12	more than 2/3
Ear problems	7	more than 2/3

Examples might be read: 38% of the population experiences headaches in a two-week period, but less than 1/2 see a physician, 32% experience a cough and 1/2 to 2/3 see a physician. Such data illustrate that patients are very active in attempting to cope with disease, and they very likely have tried to make sense of their symptoms before coming to the physician.

B. Demographic characteristics have been used to predict reactions to symptoms; e.g., Irish deny pain, Italians exaggerate pain, according to a study by Zborowski (1952). It is difficult or impossible to use a patient's characteristics to make predictions about the individual since not every Irishman will deny or every Italian will exaggerate.

C. Each individual's reaction to symptoms is unique, based on:

1. Disease experience and reactions of family;
2. Disease experience and reactions of friends;
3. Knowledge from school, media (magazines, TV.);
4. Past personal experience.

III. An example of one person's attempt to make sense of a set of symptoms.

A. The following example illustrates the process of making sense of symptoms. It is taken from the book, Heartsounds by Martha Weinman Lear (1980). The book raises many medical-social issues and is highly recommended. Read aloud the first three paragraphs of Heartsounds, on pages 11 and 12.

One might suspect that the physician in this example is more "analytical" than the typical patient, but a similar process takes place before nearly every treatment visit: the patient has at least decided that a medical explanation is a possibility that requires a physician's opinion.

IV. Next, apply this common sense process to a second symptom example, the ubiquitous experience of a headache. What does a person think of when s/he experiences a headache? What do you think of?

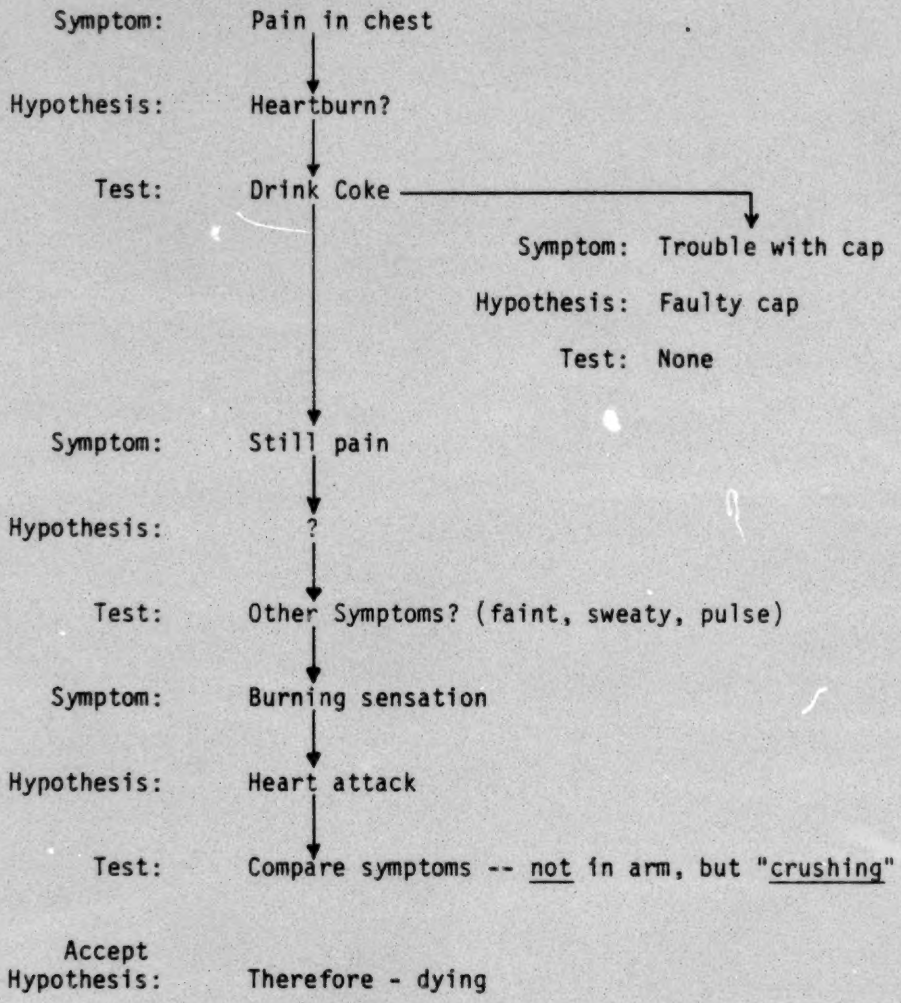
A. Have group generate hypotheses about causes of headaches. (e.g., eye strain, sinusitis, tension, migraine, etc.)

B. Ask the group about reasonable lay tests of each plausible hypothesis. (e.g., think about: drinking too much? like mother's migraines? like Excedrin headache No. 1? take antihistamine? use eyedrops?)

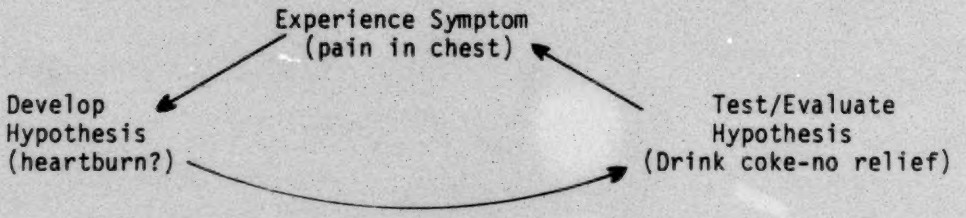
1. Point out passive kinds of testing, i.e., thinking about: (asking yourself about drinking, comparing to past headaches or other's headaches.)

2. Point out active testing, i.e., doing something: (taking a pill, using drops, etc.)

DIAGRAM OF THE ABOVE PROCESS


Symptom: Pain in chest
Hypothesis: Heartburn?
Test: Drink Coke
Symptom: Trouble with cap
Hypothesis: Faulty cap
Test: None
Symptom: Still pain
Hypothesis: ?
Test: Other Symptoms? (faint, sweaty, pulse)
Symptom: Burning sensation
Hypothesis: Heart attack
Test: Compare symptoms -- not in arm, but "crushing"
Accept Hypothesis: Therefore - dying

B. A general diagram or model of this "common sense" process might be:


Experience Symptom (pain in chest)
Develop Hypothesis (heartburn?)
Test/Evaluate Hypothesis (Drink coke-no relief)

C. Compare and contrast this common sense process to differential diagnosis.

  1. Tests of hypotheses by patients are attempts to narrow down or rule out possibilities.

  2. The patient's trial treatment is similar to medical trial treatments: "If aspirin works it must have been ..."

  3. Lay assumptions may be inaccurate, such as "mother's migraines" may be tension headaches, etc. These may require detailed patient reeducation.

  4. The outpatient visit is simply one more step in the patient's (differential diagnostic) efforts to understand disease.

V. Ask for volunteers to present overhead of recent symptom experiences.

A. Point out steps in the resident's experience: (see example of transparency, page 81)

  1. Ask resident to describe what bleeding looked like, felt like, when started, etc.

  2. Ask resident to discuss why s/he thought of anal fissure, hemorroids, cancer. Ask the group to think of other possibilities.

  3. Discuss testing procedures that the resident used. For example:

    a. Compared this bleeding to last time, assumed a fissure.
    b. Now wait and see. Ask how other possibilities were eliminated by the resident.

B. Ask the group if knowing these things are important to care; e.g. how long delay was, reason for it, etc.

VI. Recapitulate components of model. Show overhead providing sample questions to assess each component.

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TRANSPARENCY

RECENT SYMPTOM OF CONCERN

1) What did problem feel/look like.

2) What you thought it might be/caused it.

3) How did you decide what it really was and how to handle it?

EXAMPLE TRANSPARENCY

RECENT SYMPTOM OF CONCERN

1) What did problem feel/look like.

Painless rectal bleeding

2) What you thought it might be/caused it.

Anal fissure
Hemorrhoids
Cancer

3) How did you decide what it really was and how to handle it?

Have had anal fissure with rectal bleeding in past. Haven't done anything, but I keep planning to get it checked out.

EXAMPLE TRANSPARENCY

RECENT SYMPTOM OF CONCERN

1) What did problem feel/look like.

Foot pain - intermittent in same spot for 2 years.

2) What you thought it might be/caused it.

1. Recurrent ligament strain
2. Stress fracture or fracture not well healed
3. Bone cyst
4. Bone cancer

3) How did you decide what it really was and how to handle it?

I haven't done anything about it. I toy with the idea of getting an x-ray but I feel silly doing it.

QUESTIONS TO ASSESS PATIENT'S HYPOTHESES

	Questions to Ask	Justifications
Patient's Symptoms	What does it feel like? Have you (or someone else you know) ever felt this way before? When does it bother you the most?	Identifies patient's fears and expectations about outcome, demonstrates concern.
Patient's Hypothesis	What do you think caused it? What other things have you noticed, even if you don't think they're related?	May identify how patient explains problem and thus points out avenues for intervention, education. Encourages patient to report symptoms that don't fit with her/his explanation.
Patient's Testing	What have you done for your problem? What makes it better/worse?	Provides information on treatments already tested. Provides opportunity to educate patient about appropriate/inappropriate treatments.

SAMPLE QUESTIONS

What brings you in today?

What does it feel like?

Have you (or someone you know) ever felt this way before?

What do you think caused it (is going on)?

What makes you think that?

What makes it better or worse?

How long have you had it?

What have you done for it?

SEMINAR FOR MODULE 2

HOW PATIENTS THINK ABOUT ILLNESS

PART II: Difficult-to-Diagnose Cases

The goal of the seminar is to help residents appreciate their patient's perspective of illness. The seminar explores the patient's ongoing process of symptom interpretation throughout a long-term problem and probes its meaning for the physician and the patient. Just as the patient develops an informal differential diagnosis with a new symptom (see Part I), s/he continues to interpret information during the entire course of an illness. If explored, the patient's attention to body sensations can provide valuable information to the physician, but, if ignored, can lead to increased anxiety about the illness or to dissatisfaction with care.

This seminar continues the discussion of the case of Harold Lear, begun in Part I, to illustrate how the patient's body becomes the focus of his attention in a situation where the meaning of symptoms is unclear to both patient and physician. This seminar also explores the physician's multiple responses to the difficult-to-diagnose patient and the similarities to the responses of the patient whose condition is difficult to diagnose.

OBJECTIVES

The resident will discuss strategies that facilitate the patient's understanding and recall of information including:

1. The nature and impact of the process by which patients with long-term or difficult-to-diagnose problems develop and test hypotheses about the meaning of symptoms;
2. The importance of assessing patients' beliefs/thoughts about the symptoms/conditions;
3. The importance of giving patients a justification of the treatment plan;
4. The importance of preparing patients for probable sensations of the illness experience as well as probable side effects of the treatment plan;
5. The importance of assessing the symptom and/or side effect experiences of patients with long-term problems.

PREPARATION OF THE SEMINAR LEADER

The leader should be familiar with a "common sense" approach to understanding illness conditions by first reading "The Role of the Clinical Faculty" for Module 2 and the handout entitled "The Patient's Perspective on Health Problems" (p. 99). The leader should then read Leventhal's (1975) complex

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but worthwhile article "Consequences of Depersonalization During Illness and Treatment," which describes the theoretical background of this seminar. Heartsounds, by Martha Weinman Lear provides a clear illustration of the process described by Lear.

To prepare for this seminar, the leader should review Heartsounds, especially the sections noted in the seminar, and apply the stages in symptom processing described by Leventhal to the process Lear goes through.

PREPARATION OF THE RESIDENT

If the resident has not participated in Part I, s/he should read the resident handout, "The Patient's Perspective on Health Problems," (see page 99). The residents should also be encouraged to read Heartsounds, although this is not necessary for participating in this seminar.

SEMINAR OUTLINE

I. Differential diagnosis - compare and contrast methods of data collection used by patients and physicians.

   A. Symptom experience - both the physician and patient examine symptoms to develop hypotheses about cause.

      1. For the patient, symptoms are internal, ambiguous:

         a. NOVEL (not previously experienced)
         b. SUDDEN ONSET (suddenly appears)
         c. FLEETING IN OCCURRENCE (disappears, reappears...)
         d. HARD TO LOCALIZE (moves from place to place)
         e. OF VARYING INTENSITY
         f. OF VARYING QUALITY (sharp, dull, aching)

      2. Because the symptom carries a threat (or a warning), the symptom initiates a search for an explanation (see B).

      3. For the physician, symptoms are the subjective report of the patient (see 1 above).

         a. Based on medical knowledge, symptoms have meanings, causes.
         b. Because the patient's symptoms are not externally observable the physician includes laboratory and physical examination data that are external and can be validated by other professionals.

      4. For the physician, the information from the patient and other observations and tests also initiates a search for an explanation (see 2 above).

   B. Hypothesis development/developing the differential diagnosis:

1. To determine the meaning of a symptom, the patient must put together the sources of information that s/he currently has at her or his disposal. This information pertains to:

    a. The characteristics of the symptom that the patient noticed - we discussed above how difficult this is to describe/pinpoint.
    b. Other sensations, including:
        i. How else do I (you) feel?
        ii. Anything else hurt, feel different?
    c. Present physical condition, recent exposure, including:
        i. What have I (you) eaten, drunk?
        ii. How much sleep have I (you) had?
        iii. Is anyone around me (you) sick?
        iv. Am I (are you) under stress?
    d. Knowledge/experience, including:
        i. Experience with illness
            a. Same or similar condition in self
            b. Same or similar experience of family, friend
            c. T.V., magazines, movies presentation of condition.
        ii. Medical knowledge from school, reading, experience with medical settings, etc.

2. Information is used to:

    a. Identify causes of the symptom(s) - can restrict or expand number of plausible causes:
        i. If sore throat has always been defined (and treated) as strep, strep may be the only plausible hypothesis.
        ii. If a bloody stool has meant hemorrhoids for the patient, ulcerative colitis for her mother, and cancer for her father, the patient has at least three hypotheses.
    b. Estimate consequences of the symptom(s)
        i. Of disease/condition (Will I become sterile?)
        ii. Of treating disease/condition (Will I be bedridden for 1 month?)

3. The physician follows established medical algorithms in developing the differential diagnosis using available information:

    a. Subjective patient reports
    b. Objective observations and tests
    c. Medical knowledge

C. Hypotheses testing/diagnosis:

1. The patient tries to decide on the most accurate hypothesis (to guide coping with problem) by testing the hypotheses s/he has generated. The testing can be passive or active:

    a. Can think about it
        i. This headache is a plausible consequence of drinking too much last night. Therefore, I'll suffer through it and see how I feel tomorrow.

        ii. "If it's food poisoning, my wife should have it, too. I'll ask her."
    b. *Can manipulate or test solutions*
        i. "This lump on my breast feels sore, so it's not cancer. It must be a bruise."
        ii. "Must have been a sour stomach. The Tums worked fine."

2. The physician makes the diagnosis by using a similar but more rigorous medical method.

D. Consequences of ambiguous results of tests of hypotheses on differential diagnosis

1. For patient - ambiguous results may be due to poor reasoning, information, or actual nature of condition.

    a. Example: First, Tums don't work.
       Second, no one else seems sick.
       Third, the problem doesn't diminish with time.

2. Without an explanation (which usually suggests a method of coping) the search intensifies:

    a. Symptoms: Body becomes focus - "What else do I feel?" "Can I make symptom worse or better by moving around, pinching it...?"
    b. Hypothesis: What else might it be? Less likely explanations are considered because more plausible ones have been ruled out (if headache doesn't respond to Excedrin, maybe it's a brain tumor?)
    c. Hypothesis Testing: What else can I try...to understand it...to get relief?

3. For physician, ambiguous results lead to a similar process:

    a. "Am I missing something?"
    b. "Is this a mysterious new disease?"
    c. "Should I consult a specialist?"
    d. "Do more tests?"
    e. "Wait and see?"

II. The patient with a continuing illness - how patients attend to more body cues than they or their physicians can cope with.

A. Example of Harold Lear from Heartsounds

1. During several periods in his illness, Lear developed symptoms that troubled him, but his physician dismissed. Lear, a physician, goes through a number of medical and nonmedical tests to develop hypotheses which can account for the sensations he experiences.

2. Present flow sheet of Lear's serial symptom testing. (See pages 4 and 5).

3. Lear's experience is interesting, because even as a physician, he was not privy to the diagnostic thinking of his personal physician. Discuss one of Lear's encounters with his physician and how it might have been changed if both Lear and his physician shared the information they were using in their hypotheses.

    a. Example 1: Read from Heartsounds lines 11 through 24 of page 244. Show and discuss the flow sheet for Example 1.

    b. Example 2: Read from Heartsounds page 246, lines 13 through 27. Show and discuss the flow sheet for Example 2.

    c. Example 3: Read from Heartsounds the last seven lines of page 248 and the first four lines of page 249. Show and discuss the flow sheet for Example 3.

    d. Example 4: Read from Heartsounds the last ten lines of page 253, all of page 254, and the first 12 lines of page 255. Show and discuss Example 4 flow sheet.

B. Contrast the feelings and reactions of physician and patient in cases that are complex, as Lear's.

1. Feelings, attributions of physician - How do you feel about a patient who continues to return with a difficult-to-diagnose problem? How do you perceive the patient? Responses may include:

    a. Guilty, inadequate.
    b. Frustrated.
    c. Like I want to avoid this situation.
    d. Angry.
    e. This patient is just coming in for attention.
    f. This patient doesn't listen, doesn't try.

2. The patient's perspective: Reviewing your feelings about the ongoing process of diagnoses and your feelings about the patient, how do you think the patient feels in this situation?

    a. How does the patient reach a differential diagnosis? Do you think the patient considers the possibility that this all might be in her or his mind?
    b. Where does the patient go for consults?...Family?...Other physicians?...Nurses?
    c. You've said that you feel angry, frustrated, guilty, etc. Do you think that the patient feels similarly?
        i. Guilt - "I brought this on myself, I should be able to handle it."
        ii. Anger - "This doctor doesn't know what s/he is doing."
        iii. Frustration - "This doctor isn't listening to me."

FLOW SHEET: Example 1

Symptoms: Faint; heart felt funny

↓

Hypothesis Development: Heart problem?

↓

Hypothesis Testing: Check pulse, skipping beats

↓

Symptoms: Faintness growing

↓

Hypothesis Development: P.V.C.'s = ?

↓

Hypothesis Testing: Call physician

↓

(Rx: Try cool bath and Gatorade)

*****

FLOW SHEET: Example 2

Symptoms: Misplaced things, foggy, pulse weak, tachycardia

↓

Hypothesis Development: "My (cardiac) limitation"

↓

Hypothesis Testing: Go to bed

↓

(Note Reactions: Frustration, hide sadness from wife)

FLOW SHEET: Example 3

Symptoms: Weak, lethargic

↓

Hypothesis Development: Side effects?

↓

Hypothesis Testing: Check pulse; consider demanding more tests?

*****

FLOW SHEET: Example 4

Symptoms: Pulse going mad; missing beats

↓

Hypothesis Development: Bad position in bed causing internal pressure

↓

Hypothesis Testing: Change position

↓

Symptoms: No change

↓

Hypothesis Development: Need potassium?

↓

Hypothesis Testing: Takes potassium

↓

Symptoms: Temporarily better, then worse -- heart stopped

↓

Hypothesis Development: Interaction of medications?

↓

Hypothesis Testing: Check PDR - due to digitalis

C. Much of the frustration facing both physician and patient comes from the anger and frustration of feeling impotent, and not being able to fully share the approaches they are taking to solve the problem. Careful attention to the information needed by both parties can increase the effectiveness of the encounter.

III. Intervention

A. Many of the strategies for intervention (and more detailed data collection) are derived from the traditional medical approach to the history and physical.

B. Questions to ask the patient, and reasons why these are important are listed on pages 93 - 95, "Suggestions for Intervention." (Show on overhead). Discuss how these are similar to, and how they differ from the typical medical history. Also discuss the importance of sharing the diagnostic and treatment process when both physician and patient are trying to make sense of a complex problem.

SUGGESTIONS FOR INTERVENTION

QUESTIONS TO ASK THE PATIENT:	JUSTIFICATIONS
About symptoms:	
1. What does it feel like, remind you of? 2. Have you ever felt this way before? 3. What makes it better/worse? 4. When does it bother you the most, the least? 5. What have you done for it?	These questions elicit information that is useful for formulating a diagnosis and a treatment plan. The questions demonstrate the physician's concern and interest in the patient's problem. These questions also indicate to the patient the types of information that the physician finds helpful and helps the patient to sharpen "reporting skills."
About concerns, beliefs:	
1. What do you think it might be? 2. What do you think is causing this? 3. What concerns you the most? 4. What do you think is going on? 5. What are you afraid that this means?	1. These questions may elicit further symptom information. 2. These questions will clarify the patient's concerns and/or priorities. 3. The responses to the questions will give you a general sense of the patient's medical sophistication, understanding. 4. It is important to take the responses to these questions into consideration when discussing and justifying the plan.

SUGGESTIONS FOR INTERVENTION

INFORMATION TO GIVE THE PATIENT:	JUSTIFICATIONS
About the diagnosis:	
1. What I think is going on is _____ because ___________.	1. When a patient has an understanding of the meaning of the symptoms, s/he no longer has to be preoccupied with a search for that meaning.
2. I don't think you need to be concerned about _______ because you are not also experiencing ______.	2. If you address the patient's concerns directly, the patient will be reassured that you have understood and considered her or his perspective.
About side effects:	
1. When patients take this medication, they (often/sometimes) feel _____. If you feel this way, do this ___.	1. When patients experience unexpected sensations, they often become frightened, and may choose to discontinue treatment. If they know what to expect, and what they can do about it, they are less likely to break appointments, alter the regimen, or become distrustful of the M.D.
2. You may become sleepy after you take this medication. That means that the medication is working.	
About the course of the disease: (How long it will last, how it will feel...)	
1. A few hours after an immunization, babies often become irritable and fussy. 1 teaspoon of liquid tylenol should relieve the distress. If that doesn't work, you can call the clinic.	1. This information gives the patient an idea of what to expect and thus reduces uncertainty and anxiety.
2. The swelling should decrease slowly over the next week. If your knee is still swollen by next Sunday, call me at the clinic.	2. This information also gives the patient an explanation of symptoms and a method of coping with them, thus reducing the likelihood of inappropriate utilization of health care.
About diagnostic procedures:	
1. How the procedure will feel: I'm going to do a pelvic exam...You will feel some pressure. Most patients find this to be uncomfortable but not painful.	1. Patients are better able to tolerate a procedure when they know how it will feel.

SUGGESTIONS FOR INTERVENTION

QUESTIONS TO ASK THE PATIENT ABOUT THE TREATMENT PLAN:	JUSTIFICATIONS
About treatment: (How long it will last, how it will feel)	
1. How would drowsiness get in the way of your daily routine?	1. This information identifies barriers to following treatment.
2. How will you remember to take a pill every day?	2. It stresses importance of treatment.
3. Does the plan sound reasonable to you?	3. It provides an opportunity to choose other treatment options that overcome the barriers.
4. How much of the plan do you feel able to do?	
5. What part of this plan might be difficult for you to carry out?	4. With this information, you can provide further justification, explanation and/or negotiation of the plan, including how you prioritize its components.

THE ROLE OF THE CLINICAL FACULTY FOR MODULE 2

Module 2 sensitizes residents to individual reactions to symptoms, illness and treatment. Good communication skills are needed so that residents will demonstrate an ability to:

1. Interview patients in a manner which facilitates patient reporting of symptoms;
2. Assess patients' beliefs, thoughts about etiology/meaning of problem;
3. Assess actions the patient has taken to verify the etiology of symptoms or to relieve symptoms;
4. Assess patients' beliefs/thoughts about symptoms/conditions;
5. Assess the symptom or side effect experiences of patients with long term problems.

This section presents a format for teaching and reinforcing these communication and assessment skills within the clinical setting. The experienced clinicians have incorporated most of these skills into their clinical practices and use them in response to patient needs. The residents' ability to incorporate these skills in the clinical settings is improved through suggestions, encouragement and modeling of the skills by experienced faculty physicians.

METHODS OF TEACHING PATIENT EDUCATION SKILLS IN THE OUTPATIENT CLINIC

1. *Interview patients in a manner which facilitates patient reporting of symptoms.*

   Gathering accurate reports of the patient's symptom experience is a fundamental skill in medical interviewing. Symptoms are often difficult to describe accurately and a patient may be hesitant to report symptoms which s/he does not perceive to be directly related to the presenting complaint. For example, a patient with a headache may not mention nausea, because s/he primarily wants relief from the pain. Probing for other symptoms can therefore yield important diagnostic information and communicate the desire to understand all that the patient is experiencing. When seeing a patient with the resident, demonstrate open-ended questions that probe for additional symptom experiences such as, "What else have you noticed even if you don't think it's related to today's problem?" Alternatively, the resident can be asked for all symptoms when describing a particular patient's problems, including those not clearly related to the probable diagnosis.

2. *Assess patients' beliefs, thoughts about etiology/meaning of problem.*

   Patients' beliefs and thoughts about their problem have an important effect on their behavior in response to the problem. Assessment of these perceptions by the physician can identify areas of need for patient education so that the patient and physician have a shared understanding of the problem and its treatment. For example, a patient may come to the clinic convinced that his headache indicates a brain tumor. Unless this belief is identified and discussed, the patient may be very dissatisfied with a "cursory" examination.

When seeing a patient with a resident, demonstrate the process of assessing the patient's perception of the etiology or meaning of the problem using questions such as, "Do you have any idea what is causing the problem?" "What do you think is causing the problem?" "Does anyone you know have this kind of problem?...What was it?" The answers to these questions uncover misconceptions or inappropriate treatment expectations that need clarification.

Similarly, when a resident is describing a patient's presenting problem, ask what the patient thinks is causing the problem, thus demonstrating the importance of assessing the patient's perception of the problem.

3. *Assess actions the patient has taken to verify the etiology of symptoms or to relieve symptoms.*

Prior to consulting a physician, patients actively attempt to figure out the cause of symptoms and to relieve them. Assessing the steps the patient has already taken has two important benefits. First, this assessment can provide medical information about the disease and possible treatment, e.g., aspirin and rest have not relieved this symptom. Second, assessment creates opportunities to reinforce proper home management or correct inappropriate home remedies.

When seeing patients with the resident, ask the patient:

"What have you done for the problem?"
"Has anything helped relieve the symptoms?"

Also ask the resident what the patient has tried and discuss ways to clarify misconceptions or improve home remedies.

4. *Assess patients' beliefs/thoughts about symptoms/conditions.*

Symptoms and diagnoses can have idiosyncratic meaning for a patient. Headache, for example, can imply high blood pressure to one patient and tension to another. Because such meanings may be incorrect or lead to inappropriate treatment, they must be assessed. The assessment provides opportunities for educating the patient about her or his body and caring for it. When seeing patients with the resident, ask the patient:

"What do you know about tension headaches?"
"Is there anything about headaches that particularly bother or concern you?"
"What do you think will happen if the headaches don't get treated?"

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Such questions give the patient a chance to express concerns and beliefs about the condition and again communicate concern for the patient's point of view on her or his health.

5. *Assess the symptom or side effect experiences of patients with long-term problems.*

Long-term problems require careful assessment of the experiences of the patient. Symptom and side effect experiences can lead the patient to alter medications or drop out of treatment. These assessments communicate the physician's concern for the patient and her or his perceptions of how the treatment is progressing. An assessment of these experiences also can uncover important complications needing attention, and regimens can often be altered to minimize side effects due to treatment.

When seeing a patient with the resident, demonstrate questions which elicit the symptoms or side-effects of treatment, such as:

> "What problems have you noticed since the propranolol was added to your blood pressure medications?"
> "How have you been feeling since the treatment started?"
> "What problems are you having that you think might be related to the treatment?"

These questions allow the patient to describe her or his ideas about how the treatment is progressing and can identify side effects which need to be dealt with at the visit.

APPENDIX I

HANDOUT TO PART I

THE PATIENT'S PERSPECTIVE ON HEALTH PROBLEMS

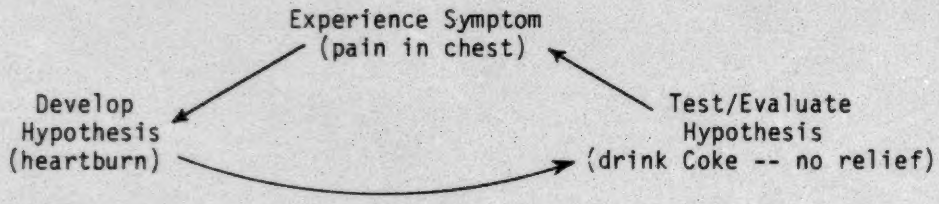
The purposes of this handout are:

1. To present a "common sense" model of how people think about disease and treatment and how to deal with it;

2. To demonstrate how an assessment of an individual's perspective on her or his illness can provide the physician with guidelines for what kind of information s/he needs to include when explaining plans to the individual. The most important point is that each patient actively uses a variety of information (present symptoms, past experience, family, friends, T.V., etc.) to make sense of and cope with disease and treatment.

Although it _is_ possible to make generalizations about how cultural or demographic groups tend to react to symptoms (e.g., Italians and Jews may exaggerate pain and Irish may deny pain, Zborowski, 1952), it is not possible to predict if an individual member of a group will react accordingly to type. The response is a product of each individual's unique experience and situation. A task of the physician is to assess how the individual patient is thinking about and dealing with the problem.

How do patients think about and deal with problems? If a person experiences a symptom, s/he begins to develop a hypothesis about possible explanations. This process is analogous to a differential diagnosis. Possible hypotheses are thus considered and accepted (or discarded) on the basis of available information, (medical knowledge, symptoms, past experience, expert referrals). The following diagram illustrates this dynamic process:

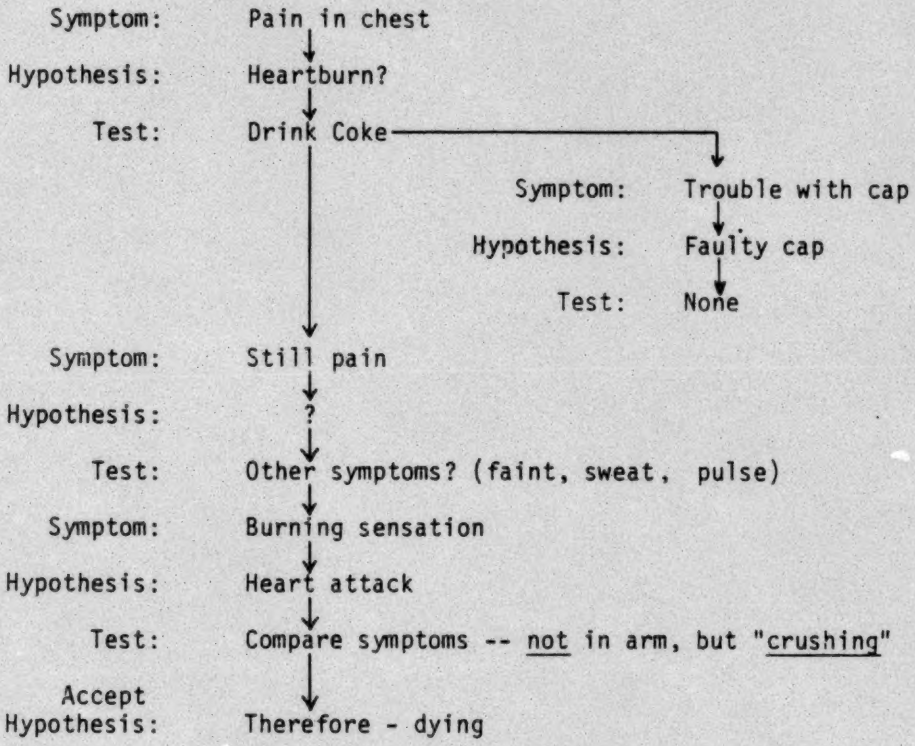


The following example illustrates the process. It is a summary of the first three paragraphs of the book _Heartsounds_ by Martha Weinman Lear (1980), pages 11-12. These are the thoughts of a 50-year-old urologist about a set of symptoms.

> Dr. Lear woke at 7:00 A.M. with pain in his chest, which he recognized as heartburn. He went to the kitchen for some Coke, which often eased this kind of pain. He experienced some difficulty in opening the Coke bottle, which he blamed on a "defective cap."
>
> Drinking some Coke provided no relief from the heartburn, so he became more observant and watched for other symptoms.

> He was breathing hard and sweating, although the air was cool. He felt his pulse, which was weak and rapid. He felt an intense burning feeling that spread over his chest toward his throat. But he noted this feeling did not move into his arm. The pain got worse, it felt crushing as patients had always described it. He grew weaker and fainter. He thought that he was dying.

DIAGRAM OF THE ABOVE PROCESS


Symptom: Pain in chest
Hypothesis: Heartburn?
Test: Drink Coke
Symptom: Trouble with cap
Hypothesis: Faulty cap
Test: None
Symptom: Still pain
Hypothesis: ?
Test: Other symptoms? (faint, sweat, pulse)
Symptom: Burning sensation
Hypothesis: Heart attack
Test: Compare symptoms -- not in arm, but "crushing"
Accept Hypothesis: Therefore - dying

One might suspect that this physician in this example is more "analytical" than the typical patient, but a similar process takes place prior to nearly every treatment visit: The patient has at least decided that a medical explanation is a possibility that requires a physician's opinion.

Consider a second example, the ubiquitous experience of a headache. What does a person think of when s/he experiences a headache? One might think about a variety of causes: eyestrain, sinusitis, tension, migraine, hangover, brain tumor. The various hypotheses can then be tested. The hangover hypothesis might be tested by *thinking* about the previous day's activities. If heavy drinking did not occur, hangover can be ruled out. The migraine hypothesis might be tested by *thinking* about past experience: "Is this like the headaches Mom used to have? -- Like the one I had last year?" A "tension" headache might be tested by thinking about or comparing symptoms to wife's, husband's or a "movie star's" tension headaches.

A hypothesis might also be tested by a more active process. The possibility of a sinus headache could be tested by taking an antihistamine. If relief follows, the hypothesis is supported, if not, further hypothesis development and testing are needed. Similarly, a caffeine withdrawal headache could be tested by drinking some coffee and watching for relief. If a person suspects a brain tumor, only a medical consultation can provide a definitive test. Often, a person considers several possibilities at once: e.g., sinus, migraine, tension, caffeine, and tests these hypotheses simultaneously by taking antihistamine, aspirin, and relaxing with a cup of coffee. While this will not provide a definitive test for each hypothesis, it may provide symptom relief.

In the context of this hypothesizing and testing that the person goes through, the outpatient office visit becomes another source of information to rule out, confirm, or identify new explanations (hypotheses) and treatments. Recognizing that the patient has been focusing on and thinking about the problem, the physician can take advantage of the process by asking the patient what s/he has noticed, what s/he thinks might be going on, and what s/he has tried before coming to the physician. These answers can provide both useful clinical data; e.g., a home treatment that worked, as well as useful patient education data; e.g., reinforce or correct home treatment.

ASKING ABOUT SYMPTOMS

Asking a patient about symptoms can be problematic, due to the nature of everyday symptom experience. Symptoms are usually vague: a headache hurts, but it often is difficult to pinpoint exactly where the pain is. A headache can vary in type and intensity of pain, move from one part of the head to another, or come and go. Thus, the physician should expect that reports of symptoms will be vague. It is difficult to say where the pain is since it moves, or is no longer present. The patient can be assisted in reporting by asking, "Have you (or someone you know) ever felt this way before? " or by asking for analogies, "Does it feel like a pin prick . . . etc." These reports can also identify fears and expectations about the problem or treatment based on memories of past experiences of self or others -- "I felt this way before my last miscarriage," or "I had to go to the hospital for three weeks."

ASKING ABOUT HYPOTHESES

Asking about the patient's hypotheses can provide important information to the physician. By asking, "What do you think caused it (or is going on)?/What makes you think that?" the physician can identify the patient's expectations for the visit, her or his medical sophistication, and any fears the patient may have in regard to the problem. For example, knowing that the headache patient suspects a brain tumor can lead to discussion and reassurance (1) about tumor frequency, and (2) how the medical differential diagnosis is made and compared to the patient's experiences. In other words, a discussion of the patient's hypotheses can be used to reinforce and/or correct the patient's ideas: "If I had that symptom, I'd also think of ..." Knowing what the patient suspects might be going on can also restrict the information s/he reports: vomiting may not "fit" with a patient's hypothesis of an "eyestrain" headache and be ignored in her or his description of symptoms. Questions like, "Even if you don't think they're related to this problem, what else have you noticed?," can avoid this kind of difficulty.

ASKING ABOUT SELF TREATMENT

Finally, asking about what the patient's done to test her or his hypotheses provides important information -- sample questions would be: What have you done (for the problem)?" and "What makes it better/worse?" Answers to these questions tell the physician how the patient generally handles symptoms -- does the patient simply want symptom relief, or does s/he want to know what the underlying cause is? Such answers also tell the physician what treatments the patient has already tried. A patient who has waited six weeks to come in may be more uncomfortable waiting for two more weeks than a patient who came in right away. Prescribing aspirin for a headache may be inappropriate for someone for whom such treatment has already failed. The tests that the patient reports provide excellent opportunities for patient education. Medically appropriate tests or treatments can be reinforced - "That's how I'd treat a sprain, too," and inappropriate ones corrected - "Bloody stools can be very serious, so you should have them checked out right away."

Assessing what the patient has experienced and how s/he has thought about and tested her or his ideas about her or his problem demonstrates that the physician recognizes the unique experience of the individual patient. It also provides useful clinical data and opportunities for patient education. This assessment of the patient's ideas allows the physician to directly address these concerns and introduce treatment plans in this context. In next week's seminar, we will discuss the implications of the patient's hypothesizing and testing process for long term health problems such as chronic pain, hospitalization and difficult-to-diagnose cases.

QUESTIONS TO ASSESS PATIENT'S HYPOTHESES

	Questions to Ask	Justifications
Patient's Symptoms	What does it feel like? Have you (or someone else you know) ever felt this way before? When does it bother you the most?	Identifies patient's fears and expectations about outcome, demonstrates concern.
Patient's Hypothesis	What do you think caused it? What other things have you noticed, even if you don't think they're related?	May identify how patient explains problem and thus points out avenues for intervention, education. Encourages patient to report symptoms that don't fit with her/his explanation.
Patient's Testing	What have you done for your problem? What makes it better/worse?	Provides information on treatments already tested. Provides opportunity to educate patient about appropriate/inappropriate treatments.

APPENDIX II

MY STYLE IN FAMILY PRACTICE*

Baldwin Lloyd, M.D.

I believe that the relationship a physician establishes with patients is absolutely essential. The patient has to develop a trust in you as their physician. It is not always love at first sight. The relationship evolves through various experiences. Perhaps it is only cleaning out the patient's ears or perhaps it is taking care of a sore throat, a sore foot, a bunion, but in that way you are developing some form of relationship. We are selling ourselves to the patient as a person with some knowledge.

EXPECTATIONS

People want to know that you are capable. They want you to be able to take care of their problems and they equate the results they have with your capability. There is a great variation in what people expect of you. When they come for their appointment, it is a matter of finding out what they came for that day, and then expanding on that to find out from them, through various means, what they are expecting of you. People have different degrees of sophistication. Take sore throats, for instance. Some people come in with a sore throat and all they want to know is whether they have a strep infection and if treatment is really necessary. However, others come in with a sore throat and expect to be treated. They are not concerned if it is a strep throat or not. They expect you to do something immediately so that they can get some relief.

REDEFINING EXPECTATIONS

In a community where I went to practice most people expected a shot of penicillin when they came in after having a cold for two weeks. They did not even want to take their shirt off so you could listen to their chest. They would ask, "What do you have to do that for?" or "Why do I have to do this? I'm not used to this sort of thing." My explanation was, "Well, I don't sell penicillin. I didn't go to school for all these years just to dispense penicillin. I went to school so that I would recognize important things for you, things that are dangerous to your health, and to use my judgment. You're coming here to get my judgment about what the correct treatment is for whatever you've got." Patient education takes place because it takes time to explain to them why you are doing what you are doing, and what you are there for. So this went on for a long time as a matter of educating people.

Most patients want to understand and they do appreciate explanations. If you make a diagnosis on their problem, explain to them why or what it is that goes into making that diagnosis. Many times it is useful to take paper and pencil and draw a diagram which they can understand. Even though you may be a lousy artist they do appreciate that you are showing them a bowel obstruction, or how the gall bladder functions and how they could get along without a gall bladder, or how they can get along without a uterus or whatever. They really appreciate that you have taken a few minutes or seconds to draw the diagram. It shows your concern for their understanding, and people like to understand.

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* This discussion was adapted from a talk given by Dr. Lloyd, Director of the Verona Clinic, at the Third Annual University of Wisconsin, Department of Family Medicine and Practice Faculty Development Weekend, May 12, 1979.

FAMILY AND OTHER SOCIAL INFLUENCES

I also have to deal with things like "grandma's salve." No matter where I have been there has always been someone who has "grandma's salve," a cure for everything! I remember a patient who came in with husk lotion all over. It is a heck of a mess to get off when you try to clean it up, but it really adheres and it draws like mad. Many people will take what has happened to a relative, or a friend of a relative, and apply it to themselves. Or the bartender has heard about someone who has had similar symptoms and he had cancer. So, you have a job of ascertaining whether the patient has cancer or does not have cancer. If you find they do not have cancer, then you have to convince them of that fact. Sometimes the bartender, or the person who lives in the house behind them, has a lot more influence on them than you do with all your medical knowledge. It takes time to overcome these influences, and to do it gracefully.

PHYSICIAN VERSUS PATIENT PRIORITIES

There are various things that turn patients off, especially early in your relationship. As physicians, we come from our training having developed a certain number of principles about how we want to be holistic or all-encompassing health givers. We have the idea that we want to cure everything. It is built in to our data base that we are going to cure disease. Along with that, we are looking at risk management and at all of the things that are going to affect this patient from now until you pass the patient on to your friendly undertaker down the street.

Timing is very important in how we approach the things that are important to us and which we believe are important to our patients. It is an awful temptation when a 330-pound, 35-year-old woman comes into your office because she is having headaches and you want to say, "Well, you know it would be really great if you could lose 100 pounds." Or you want to get engrossed in her grossness, so to speak, because her obesity really hits you in the face. Obesity is a real high-risk problem. Smoking is another one that is offensive to many of us and it is obvious when the guy has a pack sticking out of his pocket, or his fingernails are yellow, that he is smoking up a storm, and we immediately latch onto this and try to get in some very telling digs at it.

We turn some people off by focusing on what is important to us instead of listening to what is important to them. I have had a patient say to me, "Doc, that is not why I came. I came to see about a headache that has been making life miserable for me during the past two weeks. Another patient told me in these exact words: "I hate to go to that clinic. Those young guys are like crusaders. Every time I go in I get the same evangelical speech or sermon, and that is not why I went." He continued, "I know I smoke and I know it isn't good for my health, but dammit I want to do it. I've known people who've smoked all their lives and lived to be 103." The point I am making is that we have to listen to our patients. Keep our prejudices slightly subdued until we have established a trusting relationship with the patient.

A trust relationship is developed with that patient, and the chances are they are going to come to you and say, "Doc, I know I really feel guilty about my weight. I really feel badly about my smoking. My kids keep bugging me about it. Is there anything you can do to help me?" I think we have to identify the patient's priority system first and develop a trust relationship before we can truly be effective as healers or as helpers for patients. They will appreciate it if you do not aggravate their guilt system when they walk in the door.

One other thing that happens is a kind of a turn off to patients. You ask a patient what is wrong and they start to tell you, but you soon take away the conversation and start to tell them all the rest of whatever they began telling you! I have seen this happen with residents. They get impatient with a patient telling them what is going on so they take over the conversation: "Yeah, oh well, that's so and so and so," without listening to what the patient has to say. That really turns people off. They do not like to be interrupted and they do not like to think that you are so smart that you know everything about what is wrong with them before you listen to them. There are doctors who do this consistently.

Patients want to know if you are concerned about them as a person. After I get the patient's complaints, and why they are there I like to find out something about the patient. I like to find out what they do. I like to know specifically what they do, and whether they like what they are doing. I ask, "Do you really enjoy your work?" This helps to fix in my mind a name, a face, and something about them that I think is important. When I approach them the next time, I have a data base in my mind about this individual that helps me a great deal.

I have found many times you have to go this route even to find out what the solution is to the problem for which they came. I will give you an example. A young fellow came in with numbness along the ulnar distribution. I could not figure out why he had numbness until I found out he worked for the Heileman Brewing Company. I asked him what he did at the company. He said, "I run a capping machine." I asked him to explain a capping machine to me. He continued, "Well, I sit there leaning on a pipe, like a fence around there, and about once an hour I have to get up and go punch caps in a slot so they go down through the machine." I said, "What do you do the rest of the time?" He said, "Oh, I just sit there with my arms resting on the pipe." He helped me identify why he had what he had, and it was not too hard to get him to get rid of his ulnar irritation. That is quite pointed, but there are a lot of other ways that you find out about people by finding out what they do and what they like.

Some people have trouble following through with recommendations. A very simple example is with strep throat. There was a young man, whom one of the first-year residents saw. I told the resident the patient should be told that he is starting on penicillin and within 24 hours he should feel much better. But, being human, anyone who feels better thinks, "Why should I continue to take medicine?" But he must know it is very important for him to continue to take the medicine because a certain number of people get rheumatic fever from not treating it long enough. Therefore, it is vitally important - despite the fact that he feels great - that he continues taking the pills until they are gone. I said, "I know it's difficult when you feel good to remember to take pills," but I said, "Set it up in the way that you can do it." I do that unless it is someone I know who has been through it so they understand.

I learned a long time ago, especially with older people, who have not been to a doctor for a long time, that they come to you and you find they are in congestive failure. So you treat them with digitalis, cut out their salt intake, and within a few days they are beginning to feel better. You see them in two weeks, and their edema is gone, their heart is back to a normal rate, and they are getting along pretty well. A certain percentage of these people invariably stop coming in. So six or eight months later they come back and you say, "Did you take your pills?," and they say, "I felt better so I didn't take them any more," despite the fact that you told her or him specifically, "You don't stop this until I tell you to stop it." So you spend time with these people. You can spot them after awhile because they are the people who are generally pretty healthy. They are not accustomed to taking medicine, and they are the ones who do not want to buy a lock for the door because no one has ever broken in anyhow. So you spend time and you have to anticipate how they are going to feel about their treatment.

A primary concern in family practice is to get diabetics to come in on schedule. If they are new patients, they may be frightened enough so they are willing to come in. But if they have been diabetic for some period of time, and have gone to a number of doctors, they may figure they know more about their condition than their doctor. It is a difficult position to get them to adhere to any regular schedule. It is not easy to find something that works for them. But you let them know that you are concerned and that you believe that you could be of more help to them if you could see them regularly.

Instructional Modules to Teach
Primary Care Residents to Educate Patients

MODULE 3

PATIENT EDUCATION STRATEGIES FOR SHORT-TERM PLANS

MODULE 3

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INTRODUCTION

The goal of Module 3 is to present the resident with specific strategies for developing educational plans for short-term or acute-illness problems. These plans are based on the understanding of principles of communication and patient behavior developed in Modules 1 and 2.

What are the basic ingredients of a good short-term plan (one generated by the patient and/or the physician)? The first is that the behaviors needed to carry out the plan must be clearly identified. For example, daily medications involve:

1. Getting prescription filled;
2. Taking one pill before each meal (three times a day) for a full two weeks (14 days); and
3. Returning to the clinic for a follow-up appointment.

The physician must recognize and communicate the necessary behaviors required. Common problems in carrying out the plan should also be discussed. For example, if the patient forgets the pill before dinner, should s/he skip that dose, wait an hour, or ...?

A second ingredient is that the plan should be tailored to fit easily into the patient's daily schedule; when it does not, follow-through will be less likely. If a simplified regimen cannot be suggested, additional instruction is required. Another ingredient is that the plan should be justified; follow-through is more likely if the patient understands why suggested behaviors are necessary. For example, exercises to strengthen the knee can be justified as protection against further injury.

Finally, the plan should include the physician's expectations about how the patient will feel (including side effects) during the course of treatment. This is important as patients often alter or discontinue treatment on the basis of how they feel. A patient with a urinary tract infection will often experience immediate symptom relief from treatment, but must complete the regimen for cure. Such a patient might be told: "You will begin to feel better right away (if not, call me) but it's important to get all of the infection, so take one pill four times a day (before each meal and at bedtime, with a tall glass of water) until the pills are gone even though you begin to feel better before you're out of them."

The activities in Module 3 are designed to give the resident the opportunity to implement and evaluate the effects of educational planning in clinical cases. The process of educational planning is introduced in a seminar. The resident's use of educational plans is then evaluated by observation or exit interviews and feedback. Learning is reinforced in a seminar which applies these "Strategies to In-Hospital Patient Education."

OBJECTIVES FOR MODULE 3

Residents will demonstrate an ability to:

1. Prepare the patient for symptoms and sensations of examination, condition and treatment plan;
2. Assess the patient's daily schedule in order to individualize the treatment plan;
3. Provide the patient with a justification of the treatment plan;
4. Seek reactions of the patient about the feasibility of recommended behaviors;
5. Ask the patient to demonstrate skills and/or describe the treatment plan;
6. Establish specific criteria or times for follow-up or call in.

DISCUSSION OF MODULE 3 OBJECTIVES

1. *Residents will prepare the patient for symptoms and sensations of examination, condition and treatment plan.*

Ample evidence has accumulated on the beneficial effects of patient preparation for inpatient procedures in children (Skipper and Leonard, 1968) and adults (Melamed, 1977). Preparing patients for what they will see and feel during an endoscopic examination reduced the amount of tranquilizer needed (Leventhal and Johnson, 1974), and preparing surgical patients for post-surgical symptoms and sensations reduced both requests for analgesics and hospital stay (Schmitt and Wooldridge, 1973; Johnson et al., 1971). Telling a patient what s/he will feel during an examination reduces anxiety and justifies occasionally painful but necessary diagnostic procedures. Telling the patient the expected symptoms or sensations of the diagnosed condition helps the patient anticipate dealing with them and again reduces anxiety which often accompanies symptoms of unknown etiology. Informing the patient of common symptoms and sensations associated with a treatment plan helps the patient decide which symptoms are important to report to the physician and which are nuisance effects that are normally tolerated. In general, symptom preparation allows the patient to anticipate and rehearse dealing with expected effects, thus giving the patient some perceived control over the examination, the condition and the treatment plan.

2. *Residents will assess the patient's daily schedule in order to individualize the treatment plan.*

Adherence to any treatment plan is enhanced when the plan takes the patient's unique situation into account (Fink, 1977). Tailoring the plan to the patient can only be done after an assessment of the patient's situation. An important part of that situation is the patient's daily schedule. Many treatment plans require several administrations during a 24-hour period; e.g., medications, exercises, and soaks. Assessment of the patient's schedule identifies problems that the patient might encounter in carrying out the plan, demonstrates that the physician acknowledges the difficulty patients have in following complex treatment plans and stresses the importance the physician places on the plan.

3. *Residents will provide the patient with a justification of the treatment plan.*

Although some patients will simply follow any advice given by their physicians, many need and have a right to understand why the regimen is prescribed. Svarstad (1974) found that justifying the regimen was important to the patient's compliance to treatment plans. For example, a patient on antibiotics for a middle ear infection might discontinue the medicine when symptoms disappear unless s/he understands that taking all of the medicine is necessary to eliminate the cause of the problem. Providing a justification for the treatment plan does not insure adherence, but can contribute to an informed decision by the patient.

4. *Residents will seek reactions of the patient about the feasibility of recommended behaviors.*

   Although assertive patients will voluntarily challenge recommendations that appear to be unworkable or unreasonable, many other patients will not. Routinely assessing feasibility is the surest method of identifying obstacles. In the outpatient setting, following the treatment plan is dependent on the patient. It is reasonable, therefore, to ask the patient if the plan seems to be workable, since s/he is most familiar with the competing demands on her or his time, energy and other resources. Asking about the feasibility of the plan has the added advantages of suggesting first a mental rehearsal of the plan, to see if it will work (Leventhal, et al., 1965) and second, an overt commitment to following the plan (Levy, et al., 1978). Both tend to increase adherence to recommendations.

5. *Residents will ask the patient to demonstrate skills and/or describe the treatment plan.*

   Asking the patient to explain or demonstrate the regimen is a good educational technique. It can be presented as a method of assessing how clearly the physician communicated the regimen (rather than as a test of the patient's intelligence). Aside from assessing communication skills and understanding, the patient's account provides a verbal or physical rehearsal of the plan. This rehearsal shows the patient that s/he is capable of carrying out the plan and provides immediate feedback on how well s/he is performing the plan. Rehearsal can dramatically improve adherence to plans, especially over a short period of time (Leventhal, et al. 1965).

6. *Residents will establish specific criteria or times for follow-up or call in.*

   Giving the patient specific dates and times for each appointment can improve appointment-keeping (Finnerty, et al, 1973). In addition, providing the patient with specific criteria for calling in can avoid unnecessary calls and reduces dangerous delay. For example, a statement such as, "If the child doesn't start feeling better in 24 hours, call me. A little diarrhea is normal with this medication, so if nothing else comes up, come in next Thursday at 3:00," provides criteria for calling in and a specific date for follow up. Specificity about follow-up also gives the patient an idea about the typical period in which s/he can watch for treatment progress.

SEMINAR FOR MODULE 3

PLANNING SHORT-TERM REGIMENS

This seminar presents patient education strategies that residents can use to help patients carry out short-term medical regimens.

It is difficult to teach the use of specific skills in settings different from those in which the skills are used. The aim of this seminar is to present a set of strategies that will provide the resident a chance to practice them in a serial role play with colleagues. During the Observation and Feedback Activity in Module 3 the resident has the opportunity to use these strategies in clinical practice. The resident is then rewarded by better patient adherence, better medical outcomes and increased patient satisfaction.

OBJECTIVES

Residents will discuss strategies which increase the patient's ability to adopt short-term behaviors including:

1. Preparing the patient for sensations of treatment;

2. Justifying the regimen;

3. Actively seeking patient reactions about the feasibility of recommended behaviors;

4. Asking patient to demonstrate skills;

5. Establishing specific criteria for call-in/follow-up;

6. Modifying treatment based on feedback from patient.

Residents will demonstrate the use of strategies which increase the patients' ability to adopt short-term behaviors to role plays.

PREPARATION OF THE SEMINAR LEADER

The leader is encouraged to reread Module 2 materials. The background discussion of how patients make decisions about their health care presented in Module 2 suggests that patients use a variety of information to decide whether to follow treatment plans. For example, since symptom relief is often one expected outcome of treatment, a discussion of common symptoms and sensations during the course of a short-term treatment plan will provide the patient with an accurate ongoing evaluation of the effectiveness of the treatment.

Using this framework for understanding patient decision making presented in Module 2, interview several patients about their adherence to medical regimens. What parts of the regimens did they follow? What parts did they modify? Why did they make the modifications they did? What information (or lack of information) from the physician did they base their decisions on? After reading Module 1, Seminars 1 and 2, the leader should also work through several common treatment regimens to determine the detail to which they can be specified. For example, a simple antibiotic therapy for a urinary tract infection includes dosage, frequency, times of day, relationship to foods or meals, possible side effects, and duration. These details plus potential problems and resources of the particular individual's home or work environment should be kept in mind during the seminar.

As usual, the leader should read all Module 3 materials and suggested readings, paying particular attention to the "Discussion of Objectives" and the examples presented in "The Role of the Clinical Faculty" section.

The didactic presentation and first exercise in this seminar take about one hour. The role play exercise and summary can be used in the final half hour of the seminar or form the basis for a second, follow-up seminar.

SEMINAR OUTLINE

I. Patient Education Strategies for Short-Term Medical Treatment Plans.

   A. Clear instructions: In order to carry out any plan, the patient must know what it is. Clear instructions, then, are a necessary (but not necessarily a sufficient) condition for following a short-term plan.

      1. For example, Svarstad (1976) found that 54 per cent of patients who were given clear instructions followed a treatment plan completely, while only 29 per cent of the patients who received less clear instructions followed the plan completely. These numbers indicate that clear instructions improve adherence but do not insure it (see Svarstad, 1976, for details of study).

      2. In order to be clear and comprehensive about instructions to the patient, try to identify each specific action the patient needs to take in order to follow the regimen. For example, in order to specify a drug regimen, the patient must know dosage, frequency, times of day, duration of regimen, how to deal with side effects, etc. Detailed instructions can also be very effective in improving the rate of return for follow-up visits. For example, Leventhal et al. (1965) dramatically improved the proportion of college students coming in for tetanus shots by tracing each student's daily schedule on a campus map and pointing out the path that came nearest the student health service.

   B. Justification of treatment plan: A second obvious strategy to improve adherence is to give the patient a rationale for the plan that s/he can understand. Once again, Svarstad's (1976) study provides research support: when physicians provided patients with justifications for the treatment, such as "Your blood pressure is still high, so I would like to change the blood pressure medicine," 55 per cent adhered to the new regimen, whereas only 27 per cent of patients adhered when they were not given justification for the treatment.

C. Preparation for symptoms and sensations of treatment and condition: preparing patients for what they will feel during the treatment process reduces anxiety about physical changes that are taking place, and may improve adherence since the patients will know what the sensations mean and how to deal with them. A series of studies by Johnson and colleagues (see, for example, Johnson et al., 1971) showed that preparing patients for sensations and providing them with methods of coping with them reduced anxiety and improved treatment outcomes for diagnostic and surgical procedures.

   1. Be explicit about what you are treating and what you expect from treatment.

      a. "Your sore throat should go away in two or three days."
      b. "In two days you should be able to..."

   2. Patients may be surprised by your expectations about outcome. You may expect slower or different changes than the patient.

      a. "The pain will go away in a day or two, but you'll need to take the medicine for two weeks to wipe out the infection."
      b. "The medicine probably won't make you feel any different, but it will help your..."

   3. Discuss side effects and how to deal with them:

      a. "I don't expect you'll have any problems with this medicine. You may notice a little light-headedness, and you shouldn't drive your car until you see how the medicine affects you."
      b. "If your stomach gets upset after you take the medicine, either drink a glass of milk, or always take the medicine just before you eat."

D. Assessment of patient's ability to carry out the plan: patients vary widely in their ability to understand and carry out a treatment plan. It is important to find out what the patient has understood about the plan.

   1. Simply ask: "Just to be sure I've been clear about the plan, tell me what you plan to do."

   2. For more complex treatment such as a set of specific exercises, you can ask: "Will you be able to carry out this plan? What things would make it easier? What things are you likely to modify?" If you get an idea of the patient's limits, you can set priorities for treatment; e.g., "If you are able to do only one thing, do the exercises. The pills just treat the discomfort, but the exercises will heal the problem."

E. Verbal or physical rehearsal of plan: although the patient may be able to tell the physician a pill schedule, s/he may not be able to anticipate problems with following the schedule until s/he mentally (or physically) walks through a typical day, inserting the required behaviors into it.

1. In describing the steps of the plan for a typical day, the patient can identify potential problems in following it or misunderstandings of specific parts of it.

2. In physically demonstrating what they will do, the patient learns:

    a. S/he can do the prescribed behaviors;
    b. S/he is doing them correctly;
    c. How it feels when they are done correctly;

    This is a particularly good strategy for complex behaviors like breast self-examination, diaphragm insertion, or Williams' exercises.

F. A plan for follow-up: if patients are given a clear plan for follow-up on short-term problems they have a clearer idea about what the physician expects of the course of treatment and its outcome. This reduces the chances of inappropriate visits or needless delay with unrecognized complications.

1. The plan should provide concrete criteria for improvement that the patient can monitor, such as sensations or visible signs.

    a. "When your scar starts itching, that's a sign it's healing."
    b. "If your rash doesn't improve in seven days, come back."

2. The plan should be specific about when the patient should return.

    a. "If doing well, no need to return, but if no better, come in next week Friday."
    b. "When do you think you should come back in?" This gives the patient some choice and can identify inappropriate expectations. If no return visit is anticipated, but a recheck is necessary, such as for otitis media, the return can be discussed and justified.

II. Planning Treatment.

A. Overview: During this part of the seminar, residents are asked to develop a short-term patient education plan for a hypothetical patient, "Ms. Smith." The strategies that were presented in the first part of the seminar are used in the development of the plan. The seminar leader then helps the residents to evaluate Ms. Smith's plan, using the "Checklist for Patient Instructions." Methods of incorporating unused strategies into the plan are discussed.

B. Patient Problem: Ms. Smith, a 35-year-old accountant, is seen in the clinic for low back pain. An examination is negative for disc problems, although Ms. Smith does seem to have muscle spasms in her lower back. The physician recommends that she take a muscle relaxant, do exercises, and modify her sleeping and sitting positions to ease the strain on her lower back.

C. Instructions.

1. Read "Patient Problem" from (B) above to the residents.

2. Ask the residents to brainstorm as a group to develop a patient education plan for Ms. Smith, using the strategies which were discussed in the first half of the seminar.

3. Request that the residents call out specific strategies for Ms. Smith's plan. Examples: "I would show Ms. Smith how to perform the exercises, and then ask her to demonstrate the exercises for me." "I would ask her how she was going to incorporate exercises into her daily routine."

4. Explain that you will role play Ms. Smith for purposes of clarifying her response to the treatment plan. Example: If a resident wanted to ask how Ms. Smith would modify the treatment plan, you, as Ms. Smith, might reply: "I would take the medicine, do the exercises and sit the way you suggested when I sit. But I don't think I could change my sleeping position. I wouldn't be able to sleep."

5. Use "Checklist for Patient Instructions" to discuss Ms. Smith's plan. Ask the residents to give a specific example of each strategy they used. Example: "Yes, the instructions specified how often she was to take the pills. I told her to take them three times a day." Discuss ways that unused strategies could have been incorporated into the plan.

III. Role Play.

A. Overview: Residents are divided into groups of three for a role play of a patient education planning session. Scripts for physician, patient, and observer are given to each group. The observers are asked to use the "Checklist for Patient Instructions" to evaluate the adequacy of the plan. At the end of the role play, the observer comments on the findings. Participants change roles, and repeat the role play. After three role plays, the residents form a large group to discuss the role plays.

N.B. This exercise can be used in conjunction with or in place of the previous exercise, "Planning Treatment."

B. Role Play Scripts.

1. Patient script: You are a primary care resident. You have just come in to the clinic with severe pain in your right knee. You have been told that your right knee cap was dislocated and has been reset. You are concerned that the medications that will ease your pain will also dull your senses. You wonder how you will be able to drive and to move around.

2. Physician script: Your patient is a primary care resident. The patient is in severe pain from a dislocated patella which you have just reset. You are about to discuss a treatment plan that includes:

   a. A strong analgesic
   b. Knee immobilization for two weeks
   c. Quadricep exercises two times per day
   d. A return visit for follow-up.

3. Observer script: Record on the "Checklist for Patient Instructions" each patient education strategy that the physician uses when discussing the treatment plan. If you are able, note a specific example of each strategy. You will share your findings with the other two members of your group when the role play is finished.

C. Role Play Instructions.

1. Divide residents into groups of three. Give each resident a "Checklist for Patient Instructions." Give each group scripts for physician, patient and observer.

2. Announce that the role play will last 10 - 15 minutes.

3. At the end of the role play, ask the observers to take five minutes to discuss their findings with the other members of their group.

4. Repeat this process two times, asking participants to change roles each time.

5. When all three role plays are finished, ask the residents to return to a large group for discussion.

D. Discussion. Ask residents:

1. As observers, did you notice that the role plays changed from round to round? How did they change?

2. How much negotiation went on between the physicians and the patients?

3. Did the physicians become more detailed in their description of the treatment plan?

4. As patients, how much of the plan would you have carried out?
5. How would you have modified the plan?
6. How would you decide which part of the plan to carry out and which part to ignore?
7. As physicians, which patient education strategies did you incorporate into the plan?
8. Which strategies did you leave out or modify? Why?
9. Which strategies were difficult to incorporate?

Resident Handout

Checklist for Patient Instructions

		Yes	No	Comments
INSTRUCTIONS				
Do they specify	duration of therapy	___	___	
	how often	___	___	
	at what times	___	___	
	(if other than meds.)	___	___	
	how to do required behavior	___	___	
Do they include justification of regimen		___	___	
PREPARATION				
Is patient informed of	course of condition	___	___	
	possible side effects	___	___	
ABILITY TO CARRY OUT PLAN				
	Is understanding assessed	___	___	
	Does patient give weight to M.D. priorities	___	___	
	Does M.D. modify treatment	___	___	
REHEARSAL				
Is patient asked to	describe how s/he will do regimen	___	___	
	demonstrate	___	___	
FOLLOWUP PLAN				
Is patient given	criteria to evaluate her/his own progress	___	___	
	the opportunity to specify her/his own criteria for improvement and followup	___	___	

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EXIT INTERVIEW AND FEEDBACK
ACTIVITY FOR MODULE 3

INTRODUCTION

Patients often leave the physician's office with a misunderstanding of the treatment plan or inadequate information to carry out the plan. Because many patients with short-term problems do not schedule follow-up visits, physicians do not identify these misunderstandings until complications arise. The "Exit Interview and Feedback Activity" is designed to provide the resident with immediate feedback about her or his ability to develop and communicate treatment plans for short-term problems. The exit interview offers an alternative or a supplement to the observation of the clinic visit by directly assessing the patient's understanding of the treatment plan after the visit.

OBJECTIVES

The resident will demonstrate skills in developing and communicating treatment plans for short-term problems by:

1. Giving clear, behavior-specific instructions;
2. Assessing a patient's daily schedule and adapting the treatment plan accordingly;
3. Identifying and addressing a patient's expectations;
4. Providing for verbal or behavioral practice of a plan by a patient;
5. Preparing a patient for potential symptoms and side effects;
6. Providing a patient with specific follow-up plans;
7. Giving a patient written instructions and/or handouts.

PREPARATION OF THE INTERVIEWER

In order to carry out this activity, you need a thorough understanding of strategies for developing treatment plans for short term problems. This can be attained by reading the seminar, "Developing Short-Term Treatment Plans," and the "Discussion of Objectives for Module 3." Also, become familiar with the exit interview grid described below.

Tell the resident that the purpose of the interview activity is to provide the resident with immediate feedback about a patient's understanding of a treatment plan after a clinic visit. Explain that you will assist the resident to improve her or his skills in developing short-term treatment plans. Ask each resident to identify two or three patients who have a health problem which is likely to require a short-term treatment plan. Examples are: otitis media, ankle sprain, back strain or minor burn. Patients with more complicated or long-term problems can also be interviewed, but Modules 4 and 5 are designed specifically to address long-term patient education issues.

INSTRUCTIONS FOR THE INTERVIEW

The exit interview, which lasts about ten minutes, is designed to immediately follow a clinic visit. A quiet private room is necessary to create a relaxed atmosphere for the interview, and to insure confidentiality.

Before starting the interview obtain the informed consent of the patient. Explain that:

1. The purpose of the interview is to find out the patient's understanding of treatment plans developed during the visit and to identify ways in which the physician can improve her or his skills in developing and communicating treatment plans.

2. The patient has the right to refuse permission to:

   a. Be interviewed;
   b. To continue an interview;
   c. To answer any question.

   Such refusal will not affect the patient's ability to receive care at the clinic.

3. Anything said during the interview will be shared with the resident and the resident's supervisors, but will otherwise remain confidential.

4. The interviewer cannot answer questions about the patient's condition or treatment plan. Such questions will be referred to the patient's physician.

The Exit Interview Grid is divided into eight columns (see Exit Interview Grid, p.127). The grid provides a structure for recording a patient's report on a physician-patient encounter. The interviewer asks the patient about statements made by the physician which correspond to each column in the grid. The grid is designed to include information on all problems discussed during the visit. It is easiest to separate information on each problem with horizontal lines (see sample grid, p.128).

The following outline suggests questions to ask the patient for each column of the grid. See also the completed sample of the Exit Interview, p.128.

1. Patient problem: In this column record the patient problem(s).

   a. What problem(s) did you discuss? What was the problem(s) you came in to see the doctor for today? Anything else?
   b. Did you and the doctor discuss anything in addition to the problem(s) that you came in for? What was that?

2. Behavior and instructions: In this column record the instructions as the patient understood them.

    a. For ______ (each problem identified), what did the physician suggest that you do to treat it? Anything else?
    b. (For medication) How many times a day are you supposed to take the medication? For how long?
    c. (For exercise) How many times a day are you supposed to do your exercises? How many minutes each time? When can you discontinue the exercises.

3. Expectations: In this column record the patient's concerns.

    a. What problem(s) did you want to discuss with the doctor today?
    b. Did you leave feeling that you still have concerns that the doctor didn't address?
    c. Did you get what you wanted from today's visit?

4. Assess patient's daily schedule/routines: In this column record opportunities to adapt the treatment plan that are explored.

    a. Did the doctor ask about what you do during a normal day?
    b. Did the doctor try to help you plan how you would schedule your medications? What did s/he do?

5. Verbal/behavioral practice: In this column record opportunities the patient had to describe or rehearse how s/he will carry out the plan.

    a. Did you have an opportunity to tell the doctor how you understood you should take the pills. (follow the diet? etc.)
    b. Did the doctor show you how to do the exercises?
    c. Did you have the opportunity to show the doctor how you would do the exercises at home?

6. Symptom preparation: In this column record symptoms and sensations the patient has been prepared for.

    a. Did the doctor describe how you will feel as you are getting better?
    b. Did the doctor tell you any signs or symptoms to watch for?
    c. Did the doctor describe any side effects that ever happen to people who take the medicines you will be taking?

7. Follow-up plan: In this column record specific follow-up plans.

    a. Did the doctor tell you when to come back?
    b. Did the doctor tell you to call if you have problems? What problem(s) did s/he tell you to call for?

8. Written instructions and handouts: In this column record any written information the patient received at the visit.

a. Would you show me any written instructions or handouts the doctor gave you?

After the interview, when thanking the patient for her or his cooperation, suggest that the patient contact the physician to clarify or resolve any unanswered questions or misunderstandings.

Module 3

EXIT INTERVIEW GRID

Date ____________________

Physician ________________ Patient ______________

Interviewer ______________

1) Patient Problem	2) Behaviors and Instructions	3) Assess Schedule	4) Expectations	5) Verbal/ Behavioral Practice	6) Symptom Preparation	7) Follow-up Plan	8) W.I./H.

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Module 3

SAMPLE
EXIT INTERVIEW GRID

Date 10/1

Physician Sweeny Patient Mary

Interviewer Fass

1) Patient Problem	2) Behaviors and Instructions	3) Assess Schedule	4) Expectations	5) Verbal/ Behavioral Practice	6) Symptom Preparation	7) Follow-up Plan	8) W.I./H.
Hypertension	Keep on taking meds. Relax. Stay away from sodium. HCTZ-1 in A.M. OJ, banana.	Take pills in A.M. Relax PRN	Controls own BP. M.D. just helps	Yes - fruit, pills each morning	Warned about urination	RTC March	W.I.
Pap smear Worried about breast lump Need tetanus	Not cancer	No	Expected that doctor would know what lump was	M.D. assessed patients performance of self-exam	Understand that lumps get larger with period	Yearly	Given BSE pamphlet
Problem in heart Strong family history of premature cardiac disease	Come back for blood test Don't smoke Watch for enlarged heart	No assessed daily routine, exercise	Talk about diet later, wants doctor to be "on top" of her problem	Practiced feeling for enlarged heart		Call, if headaches, chest pains Come back 1 week for test results	

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OBSERVATION AND FEEDBACK ACTIVITY FOR MODULE 3

The observation and feedback activity is repeated in Module 3 to provide residents with the opportunity to practice and receive feedback on their skills in educating patients to carry out treatment plans for short-term problems. This activity builds on the skills the resident has learned in Modules 1 and 2. It uses the resident's experiences with patients to show the need for detailed and clear planning, the importance of justifying the treatment plans, and the value of assessing the patient's ability to carry out the recommendations for treatment.

During this activity, the observer pays particular attention to the residents' performance of the criteria which correspond to Module 3 objectives:

B.3. Did the resident justify the regimen to the patient?
B.4. Did the resident prepare the patient for symptoms and sensations?
B.5. Were alternative treatment plans discussed with the patient?
C.3. Was the patient asked to demonstrate understanding of the plan (physically/verbally)?
C.4. Were criteria or times set up for follow-up or call-in?

PREPARATION OF THE OBSERVER

Carefully read all of the Module 3 materials in this manual. Pay particular attention to the Module 3 "Discussion of Objectives," "Role of the Clinical Faculty," and the "Justification of Criteria" (Appendix, Module 1). These materials provide specific examples and a logical justification and references to relevant research studies for each behavior described in the Module 3 objectives and the observation protocol criteria.

Read about the techniques and benefits of adapting treatment plans to patient needs. Of particular interest is Fink's (1977) article that discusses methods of tailoring treatment plans to fit patient schedules and to help solve problems patients anticipate. Swain et al. (1979) discuss a successful method of negotiating with patients to allow them to establish the regimen. Although the suggestions in these articles may not be directly applicable to the primary medical care setting, they provide an overview of the range of options available to the resident.

When co-workers, friends, or relatives describe their experiences with physicians listen for examples of Module 3 objectives. Note, for instance, whether these patients were prepared for the symptoms and sensations of their condition and treatment plan. The discussions by two young mothers on how they handled giving their babies an antibiotic illustrate some of the problems that can arise when a patient is neither prepared for symptoms and sensations nor given a justification of the treatment plan.

1. "He couldn't stand the taste and he kept spitting it back at me. So I stopped giving him the medicine. I figured it must be bad for him."

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If this patient had been told that although her baby might not like the antibiotic she should be sure to give it to him or he would not get well, she probably would not have discontinued the medicine.

2. "I know the doctor said to give all of the medicine to the baby, but it was hard to give him the right amount without spilling it. I stopped giving it as soon as his symptoms went away."
   This mother might have given her baby all the medicine if she had been told that the baby's symptoms would disappear in three days, but that the germs would still be in her baby's body and would eventually make the baby sick again unless all of the medicine was taken.

When feedback is given, it is useful to mention anecdotes like the above to a resident. These anecdotes provide examples of the consequences of inadequate patient education for short-term treatment planning.

Strategies developed by patients to facilitate carrying out a treatment plan can also be described to residents during feedback sessions. Examples: "I had a lot of trouble giving my baby the medicine until I got the 'test tube spoon' at the pharmacy. It made it a lot easier to give her the right amount without spilling." "I kept a checklist on the refrigerator door so I could mark down each dose of medicine I gave my baby. That way I remembered to give him all the medicine."

Residents can be encouraged to share these strategies with other patients to facilitate their adherence to treatment plans.

PREPARATION OF THE RESIDENT

Before observing a resident, briefly discuss the objectives of Module 3 with the resident and give a rationale example for each one. Tell the resident which observation protocol criteria will be focused upon during the observations.

INSTRUCTIONS FOR OBSERVATION AND FEEDBACK ACTIVITY

Follow the Observation and Feedback Procedure instructions in the Appendix to Module 1 in order to:

1. Schedule observation and feedback sessions.
   N.B. Module 3 deals specifically with short-term patient education strategies. However, it is important for the observer to realize that chronic problems, as well as acute problems, include these approaches. There is no need in Module 3 to limit observations only to short-term problems. The hypertensive patient, for example, needs to be prepared for symptoms and sensations of treatment, and to be given specific criteria for follow-up visits.

2. Observe each resident for at least three encounters.

3. Fill out an observation protocol for each encounter.

4. Prepare written feedback for each encounter.

5. Give each resident written and verbal feedback for each encounter.

When filling out the observation protocol:

1. Fill out the entire Behavior Checklist.

2. Record under "Examples" resident statements and behavior which are connected to the Module 3 observation protocol criteria (see page 129). Also, record resident statements and behavior which indicate that a resident has or has not mastered the skills taught in Modules 1 and 2. The following criteria taught in the first two modules are critical to effective patient education for short-term strategies:

Module 1 criteria:

A.5. Did resident use words the patient could understand?
B.1. Did resident encourage/respond appropriately to patient questions?
B.3. Did resident justify regimen to patient?
C.2. Was patient provided with written instructions?
C.6. Did resident repeat conclusions/instructions at end of visit?

Module 2 criteria:

A.1. Did resident explore patient's concerns/reason(s) for visit?
A.3. Did resident ask about self-treatment prior to clinic visit?
A.4. Were the effects of ongoing therapy monitored? (effectiveness/problems)?

When preparing feedback:

1. Label the behavior you wish to discuss.
Example: "You provided the mother with specific criteria for follow-up."

2. Cite a specific example of the behavior from the encounter:
Example: "We'd want to see him right away if :
    1. He showed signs of dehydration.
    2. He had a fever of 102 or greater.
    3. He pulls at his ear.
    4. He is vomiting.
Otherwise, bring him next Friday so I will be able to see if his ear infection has cleared up."

3. Justify the importance and impact of the behavior.
Example: "This can avoid unnecessary visits and reduce dangerous delays."

4. Give a specific suggestion for change for each improvement you want the resident to make:
   "The mother would be better able to decide if her child was dehydrated if you described what he would look like if he were dehydrated. You could tell her that:
   1. His skin could feel dry.
   2. His tongue would not be moist.
   3. His skin wouldn't bounce back when it was touched.
   4. His eyes wouldn't tear."

The strategies taught in Modules 1 and 2 are essential to the provision of adequate medical care.

If you find that a resident has not mastered the skills taught in Modules 1 and 2, focus feedback on the Module 1 and 2 criteria. A major advantage of the Observation and Feedback Activities is that they allow the individual needs of each resident to be addressed. In order to carry out a treatment plan, a patient must understand what the plan entails and how to carry it out. Without this knowledge, a justification of a plan and preparation for anticipated symptoms and side effects are not useful.

During verbal feedback, stress the connection between the behaviors that have been discussed and the material presented in the Module 3 seminars. Suggest that residents read Fink's (1976) article that discusses methods of tailoring treatment plans to fit patient schedules and to help solve problems patients anticipate. As an alternative, suggest that a resident read the "Justification of Criteria," or the Module 3 "Discussion of Objectives" and "The Role of the Clinical Faculty."

SEMINAR FOR MODULE 3

PATIENT EDUCATION IN THE HOSPITAL: A REVIEW OF SHORT-TERM STRATEGIES

The educational needs of the ambulatory patient with an acute problem are quite similar to the needs of a hospitalized patient. Both are experiencing a barrage of confusing physical sensations, from post operative reaction to anesthesia, to stomach upset caused by an antibiotic. Both worry about the outcome of their condition, and both are more satisfied with treatment if they receive clear explanations about what is happening to them. The primary care physician can take advantage of her or his experience following a wide variety of patients from diagnosis through hospitalization and recovery to prepare other patients for symptoms and sensations of the procedure and the recovery period.

This seminar uses the example of the hospitalized patient to demonstrate the importance of preparing patients for the symptoms and sensations of their condition and its treatment and the value of justifying treatment plans to patients.

OBJECTIVES

The resident will:

1. Describe the benefits of preparing patients for the symptoms and sensations of their condition and its treatment;

2. Demonstrate an ability to prepare patients for the symptoms and sensations of several conditions and/or treatments;

3. Describe the benefits of justifying the treatment plan to patients;

4. Justify the treatment plan to patients.

PREPARATION OF THE SEMINAR LEADER

In order to prepare for this seminar, the leader should review Ley's chapter on doctor-patient communication, concentrating on the studies which discuss satisfaction with communications within the hospital. The leader should become familiar with the literature on preparation for hospital procedures by reading the classic study by Egbert (1964) and also Melamed's chapter, "Psychological Preparation for Hospitalization," (1977) which provides an excellent summary of pediatric studies. A review of the effects of sensory information on the reduction of distress from medical procedures is found in Leventhal and Johnson (1980), or in the original articles by Johnson and her colleagues (Johnson, et al. 1978; Johnson and Leventhal, 1974; Johnson, Morrisey and Leventhal, 1973).

In this seminar residents are asked to review a film or puppet show used to reduce the anxiety of pediatric patients entering the hospital. This exercise is most effective if material reviewed is used at local hospitals. Many pediatric wards use puppet shows or films to prepare young patients for the hospital experience. First, find out what materials, if any, are being used in local pediatric wards. Review these and select one film or puppet show to present in the seminar. If a puppet show is used, videotape the show, if possible, or invite the puppeteers to attend the seminar.

If the local hospitals have no formal mechanism of preparation for pediatric patients, films can be rented from various sources. A partial list of these films is:

1. Ethan Has An Operation, Health Sciences Communication Center, Case Western Reserve University, Cleveland, Ohio 44106;
2. When a Child Enters The Hospital, Polymorph Films, Bostom, Massachusetts;
3. Linda: Encounters In The Hospital, UCLA Instructional Media Library, Los Angeles, California.

Other films for preparing pediatric and adult surgical patients can be found by consulting the Library of Congress Catalog (National Union Catalog): Films. The review activity can also be adapted for review of adult surgical preparation films. Most of the commercial patient education companies include films to prepare the patient for various elective surgeries, such as knee surgery or hysterectomy. Addresses of these film suppliers are listed in Module 6.

PREPARATION OF THE RESIDENT

None.

SEMINAR OUTLINE

I. Discuss Studies of the Effects of Patient Preparation in the Hospital.

   A. Satisfaction

      1. Although patient satisfaction with general aspects of hospitalization was high, patient satisfaction with the nature and the amount of communication was much lower, ranging from 35% to 80% (Ley, 1977).

      2. In an experimental study, Ley et al. (1976) were able to increase satisfaction in hospital patients by devoting five minutes once a week to specifically explain and discuss the patient's condition.

B. Outcomes of care

  1. Pre-surgical education of adult surgical patients has been shown to lead to decreased use of pain relieving medications and decreased length of stay in the hospital following surgery (Johnson and Leventhal, 1980; Egbert, 1964).

  2. Pre-surgical preparation of children led to less anxiety and better recovery. Methods used included movies, booklets, nurse counseling (Melamed, 1977).

  3. Anticipation of the sensations of complex procedures such as gastrointestinal endoscopy results in improved patient cooperation and decreased anxiety (Johnson and Leventhal, 1980).

II. Discuss Features of Good Prepatory Material

A. Contains basic components of patient education outlined in Module 1.

  1. Short, simple sentences.

  2. No medical jargon.

  3. Explicit categorization.

  4. Repetition.

B. Anticipates what will happen to the patient as part of the treatment.

  1. When and where procedure will take place.

  2. How long it will take.

  3. What the usual course of recovery is.

  4. Example: "For your operation to take out your tonsils, we will wake you up about breakfast time and give you a pill to get you ready. Then we will put you on a rolling bed and take you upstairs to the operating room where your tonsils will be taken out...After about three hours..."

C. Tells patient how s/he will feel.

  1. Both during and after hospital stay.

  2. Example: "You'll feel groggy the day of the surgery and probably very thirsty; you can have all the water you want when you get back to your room. Most patients have a sore throat for two or three days and feel like they want to cough."

D. Justifies procedures.

1. Patients are more cooperative if they understand the reason they are being told to do something.

2. Example: "It's best if you don't try to talk for the first 12 hours or so, because that could cause some bleeding, but you will be asked to walk down the corridor to exercise your lungs and heart and that will help you go home sooner."

III. Activity: Discussion of a Patient Education Movie

A. Show preparation movie or puppet show selected for activity

B. Discussion of material.

1. Does the film or show have all the features of good preparatory material?

    a. Basic components.
    b. Description of what will happen.
    c. Description of how it will feel.
    d. Justification of procedures.

2. What do you think is most effective about the film?

3. What would you change, add or delete? Why?

IV. Generalize to Outpatient Procedures

A. Select a common office procedure and ask a resident to describe how s/he would prepare the patient.

1. Example: "I want to get some saliva or spit from way back in your throat, to see if you have an infection. If it's okay with her, I'll do it with your Mom first if you want to see what it's like. All you have to do is open your mouth real wide and I'll take this cotton swab and rub the back of your throat. It may feel a little scratchy, and make you gag a little."

2. Discuss and improve on example if necessary.

B. Select a second procedure such as taking a blood sample, a pap smear and repeat the exercise.

C. Both inpatient and outpatient preparation for procedures require actual knowledge of how the procedure does feel. Therefore, the physician should routinely question patients about sensations as they undergo procedures and recovery. For example, after lower spinal anesthetic in males, the penis is often the last place that feeling returns, which can be needlessly distressing to the unprepared patient.

V. Summarize Features of Good Preparation

THE ROLE OF THE CLINICAL FACULTY FOR MODULE 3

Module 3, Patient Education Strategies for Short-Term Plans, begins to delineate specific strategies which the physician can use to assist patients to understand and carry out medical recommendations. These strategies build on those taught in Module 1, Communication and Basic Patient Education Skills, and Module 2, Psychosocial Factors in Patient Education: How Patients Think About Illness. Skills for communicating clearly and for assessing a patient's perception of illness are needed in order to develop the following strategies for developing short-term plans:

1. Prepare a patient for the symptoms and sensations of an examination or condition and treatment plan;

2. Assess a patient's schedule and individualize a treatment plan accordingly;

3. Provide a justification of a treatment plan;

4. Seek the reactions of a patient about the feasibility of recommended behaviors;

5. Ask a patient to demonstrate skills or describe the treatment plan;

6. Specify criteria for follow-up or call-in.

This section presents a format for teaching and reinforcing patient education strategies within the clinical setting. The experienced clinician has incorporated most of these strategies and uses them selectively in response to patient needs. The experienced physician's ability to use these approaches selectively is most valuable to the resident in training because the resident learns the practical application of patient education strategies through experience and through the input of the faculty physicians.

METHODS OF TEACHING PATIENT EDUCATION SKILLS IN THE OUTPATIENT CLINIC

1. *Prepare a patient for the symptoms and sensations of an examination or condition and treatment plan.*

   Unexpected and unexplained symptoms and sensations produce fear, anxiety, and a search for meaning on the part of patients. A physician can help to reduce a patient's fear and anxiety by providing a description and explanation of the symptoms and sensations that are likely to accompany a medical procedure, condition, or treatment plan. Forewarned is forearmed. A patient who has been told to expect a warm flushing sensation during an intravenous pyelogram is less likely to be frightened when experiencing that sensation. Similarly, a mother is less likely to make an emergency phone call for a baby's fever if she has been told that an immunization shot usually produces fever and crankiness for a period of 24 hours in most babies. When you see a patient with a resident you can draw on your clinical experience and demonstrate describing to the patient the typical symptoms or sensations associated with procedures, conditions or treatment plans. Alternatively, you can ask the resident to describe what symptoms and sensations are typical for a particular procedure or plan.

2. *Assess a patient's schedule and individualize a treatment plan accordingly.*

Patients often have difficulty incorporating treatment plans into their daily routines. A physician can assist patients in identifying parts of their daily routines which can serve as a reminder to take a medication, perform a special exercise, or to consume a dietary supplement.

A patient who has erratic work hours may have trouble remembering to take a medication in the morning, at noon, and at night. However, if the patient regularly eats meals three times a day, s/he can be instructed to take the medication three times a day at meal times.

The above example illustrates the importance of assessing a patient's daily schedule in order to develop a treatment plan that the patient can follow.

When you see a patient with a resident you can demonstrate the process of assessing a patient's daily schedule in order to individualize a treatment plan with questions like:

"Describe your day to me."
"Are there things you do regularly every day?"
"What did you do yesterday? Was that a normal day?"

The answers will often provide information that the physician can use in helping a patient design a treatment plan which s/he can follow. A patient who is having a hard time remembering to do Williams' Exercises twice daily, may watch the morning and evening news every day. That patient could be instructed to do the exercises while watching the news.

3. *Provide a justification of a treatment plan.*

When a physician gives a justification of a treatment plan to a patient, s/he is also stressing the importance of carrying out that plan. For example, a pregnant patient who is instructed to "get exercise" is less likely to do so than is a woman who is told, "Try to walk 15-30 minutes every day. Exercise will help you get stronger. The stronger you are, the better shape your muscles will be in during labor when you really need to use them. And exercise won't hurt the baby at all." A patient who understands the necessity and desirability of carrying out a treatment plan is much more likely to do so. Also, the patients need this information to make a truly informed decision about following the plan.

When you see a patient with a resident, you can justify any recommendations s/he makes to a patient. For example: "I'd like to get an x-ray of your wrist. That way I can make sure that it's not broken," or "Try to cut down on coffee because caffeine makes a spastic colon act up. You'll feel better if you drink less coffee." When consulting with a resident about a treatment plan, ask the resident, "How are you going to explain the importance of following this plan to the patient?" or "How are you going to justify this plan to the patient?" By asking a resident this type of question, you emphasize the importance of justifying the treatment plan to a patient. If a resident questions the importance of doing so, you might ask, "What would you need to know about this plan in order to be convinced that you should carry it out?"

4. *Seek the reaction of a patient about the feasibility of recommended behaviors.*

Although assertive patients will voluntarily challenge recommendations that appear to be unworkable or unreasonable, many other patients will not. It is important to seek a patient's reaction about the feasibility of recommended behaviors, because a patient who does not perceive a recommendation to be feasible is unlikely to comply with it. A patient whose livelihood is based on driving a motor vehicle, such as a taxi or a tractor, is unlikely to take a medication which will cause significant drowsiness. A mother who has three young children at home will have a hard time getting "complete bed rest." When obstacles to a treatment plan are identified, the plan can be changed to meet the realities of a patient's life.

You can stress the importance of asking a patient about the feasibility of a plan by doing so when you see a patient with a resident. The responses from patients who are asked: "What problems will you have in carrying out this plan?" are likely to show the resident how important it is to ask each patient if a treatment plan is workable.

5. *Ask a patient to demonstrate skills or describe the treatment plan.*

Often a patient's understanding or interpretation of a treatment plan is different from that intended by a physician. A physician can identify and correct any misunderstandings by asking a patient to demonstrate prescribed exercises or procedures, or by asking how a patient will carry out a regimen. When prescribing Williams' Exercises to a patient with low back pain, a physician can ask the patient to demonstrate the exercises. The physician can then point out and correct any errors. In this manner, both the patient and the physician will be assured that the patient has an accurate understanding of the recommended exercises. Asking a patient to demonstrate exercises or procedures such as breast self-examination also serves to inform the patient of the importance the physician attaches to these recommendations.

In a similar fashion, asking how a patient will carry out a plan will identify any confusion about the plan as well as any problems the patient might have in performing the plan. Asking a patient, "How will you decrease the amount of salt in your diet?" might reveal a patient's lack of knowledge of foods which have a high salt content.

When you see a patient with a resident, you can ask the patient to demonstrate any suggested procedures or exercises. In addition, you can ask a patient to explain how s/he will carry out a plan. A mother of a young child with diarrhea could be asked: "Do you know the signs of dehydration? What are they?" An accurate response can be reinforced, an inaccurate response can be corrected, and both physician and patient will be assured of the mother's ability to assess whether or not her child is dehydrated. Prefacing such a question with an explanation that some aspects of a plan can be confusing may make a patient less uncomfortable about responding. An example: "Often patients find a plan like this hard to follow. How do you plan to take your pills?"

Asking a patient to practice a plan in this manner can dramatically improve patient adherence.

6. *Specify criteria for follow-up or call-in.*

Appointment-keeping can be dramatically improved by giving each patient a specific date and time for follow-up appointments. Instructions such as, "Come back in a few weeks if it doesn't get better" or "Come back if you get worse" can be interpreted in many ways. A physician can avoid unnecessary calls and reduce dangerous delays by providing patients with specific criteria for calling in. For example, the following provides criteria for calling in and a specific date for follow up: "If the lump is not smaller or less tender in the next four or five days, or if it gets bigger or more tender before then, I want you to call the clinic for an appointment right away. If it improves, I won't need to see you."

When you consult with a resident about a patient, you can ask the resident: "How will the patient know when to come in or call" or "What information does this patient need in order to make a reasonable decision about when to return for follow-up?" This will encourage the resident to think about the instructions patients need in order to make wise decisions about care seeking.

Instructional Modules to Teach
Primary Care Residents to Educate Patients

MODULE 4

HEALTH PROMOTION AND PATIENT EDUCATION: HELPING PEOPLE CHANGE BEHAVIORS IN THE ABSENCE OF SYMPTOMS

MODULE 4

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INTRODUCTION

A primary care physician is in a unique position to influence the health of patients through health promotion activities. The ongoing relationship between a primary care physician and a patient provides an opportunity for the physician to identify a patient's health risks and to assist the patient to make behavior changes necessary for health promotion. It is necessary for a physician to encourage patients to accept responsibility for reducing personal health risks. The patient must do the hard work: to change destructive behaviors such as smoking and overeating, and to create new habits such as exercising and taking safety precautions.

A physician's effectiveness in educating patients for health promotion is directly related to her or his expertise in applying the patient education skills and strategies taught in the first three modules.

Module 4 addresses the importance of using previously learned skills and strategies in order to:

1. Find opportune moments for the introduction of health promotion topics;
2. Assess a patient's priorities for behavior change;
3. Work with a patient to develop a long-term plan that consists of clear instructions and specific strategies.

The seminars and activities in this module explore the many factors involved in long-term behavior change and describe methods of developing individualized plans for each patient's special needs. A seminar on smoking cessation draws on the resident's personal experiences to illustrate the complexity and emotional impact of behavior change. During an observation and feedback activity individualized feedback is given on the progress each resident has made in developing patient education skills and the ability to apply those skills to health promotion topics. Through a chart review of patients seen for weight loss, data are gathered on each resident's methods of helping patients effect long-term behavior change. Chart review data are discussed individually with each resident. This provides an opportunity to reinforce a resident's skills and to suggest that a resident use new strategies to assist patients in long-term behavior change. Finally, members of community resource groups conduct a panel discussion of alternative approaches to weight loss.

OBJECTIVES FOR MODULE 4

Residents will demonstrate an ability to:

1. Elicit accurate verbal reports of health-related behaviors;
2. Introduce health promotion topics during patient visits in which other major behavioral changes are not indicated and new problems or treatment plans are not discussed;
3. Assess patient priorities for changing health-related behaviors;
4. Respond to patient interest in health promotion with specific suggestions for behavioral change;
5. Identify family members and friends who can assist the patient in changing health-related behaviors;
6. Request that the patient keeps a diary of behaviors;
7. Assist the patient in choosing a referral resource, where necessary, from a set of alternatives; e.g., Weight Watchers, T.O.P.S., clinic group, and nurse.

DISCUSSION OF MODULE 4 OBJECTIVES

1. *Residents will elicit accurate verbal reports of health-related behaviors.*

   This objective is the logical extension of interviewing and assessment skills learned in Modules 1, 2 and 3 to health promotion topics. Phrasing of questions in an open and accepting manner elicits more accurate and medically useful information than direct and often accusatory questions (Sackett, 1978). Accurate information is necessary in order to assess current health promotion needs of the patient.

2. *Residents will introduce health promotion topics during patient visits in which other major behavioral changes are not indicated and new problems or treatment plans are not discussed.*

   Ley (1977) and others have stressed the dangers of overloading the patient with information during a medical encounter. Although preventive medicine is a cornerstone of primary care, pressing problems, such as acute or complicated conditions, require the patient's and physician's full attention before any additional issues should be addressed. Routine physicals, immunizations, or follow-up visits provide more appropriate opportunities in terms of the patient's and physician's time and attention to introduce and adequately discuss preventive topics.

3. *Residents will assess the patient's priorities for changing health-related behaviors.*

   Often physicians and patients are not in total agreement about priorities for changing health-related behaviors. Since changing any behavior is difficult, it is important to assess the patient's priorities. This involves the patient in the process of deciding on changes and can result in a shared understanding of plans and goals for change. Since the patient is the person who has to carry out the actions, her or his active role in the decisions is crucial to follow-through (Shulman, 1979; Swain, 1980).

4. *Residents will respond to patient interest in health promotion with specific suggestions for behavioral change.*

   Although a patient may be able to identify a needed change in behavior, s/he may not be able to specify methods for change. Vague recommendations such as "lose weight," or "stop smoking," can be frustrating because of past failures. Providing specific methods for change shows the patient that workable solutions exist, that the physician is available to assist in the change, and that the patient is the person responsible for affecting the change (see Thoresen and Mahoney, 1974).

5. *Residents will identify family members and friends who can assist patient in changing health-related behavior.*

   Although the patient may be ultimately responsible for carrying

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out the health promotion activity, family and friends can be an important source of support and assistance (Fass, 1978). Health promotion recommendations such as weight loss or exercise often require changes in eating habits or daily routines that affect the entire family. Without the active assistance and encouragement of family members, these changes can be difficult or impossible to carry out.

6. *Residents will request that the patient keeps a diary of behaviors.*

Since most health promotion activities require changing long-standing habits that are almost second nature, such as smoking, eating and exercise, a very effective technique for identifying potential interventions is a diary of behavior. Mahoney and Thoresen (1974) argue that such "self-observation" is a critical first step for behavior change. To keep a diary of behaviors is also a fairly simple task compared to changing a habit and gives the patient an achievable first goal toward change.

7. *Residents will assist patient in choosing a referral resource, where necessary, from a set of alternatives; e.g., Weight Watchers, T.O.P.S., clinic group, and nurse.*

A great deal of time and effort is required to start and to maintain a change in behavior. Often, to save time and costs, a patient can turn to other resources for health promotion activities. With many more resources now available, (Preventive Medicine, USA; 1976) the patient is able to select the program most suitable to her or his needs.

SEMINAR FOR MODULE 4

HELPING PEOPLE QUIT SMOKING

The goal of this seminar is to demonstrate the difficulty of changing personal habits and to suggest strategies which residents can use to help patients make desired behavior changes. Although discussion focuses on problems of smoking cessation, each resident is also encouraged to examine personal behaviors that would be difficult to change. The discussion of personal behavior change familiarizes residents with the barriers to behavior change and the need for long-term and often detailed planning to change deeply-ingrained or valued habits.

OBJECTIVES

The resident will:

1. Identify those life events likely to motivate patients to stop smoking, such as pregnancy or chronic illness;
2. Identify strategies for helping smokers quit;
3. Discuss how people can use failures at stopping smoking as learning experiences.

PREPARATION OF THE SEMINAR LEADER

Numerous books and articles have been written about the health effects of smoking and strategies for helping individuals to quit smoking. The Smoking Digest (1977) provides a capsule summary of the problems of smoking and smoking cessation programs as well as a good bibliography. Leventhal and Cleary (1980) provide a theoretical review of methods of changing smoking behavior, while Danaher et al. (1980) present practical suggestions for the clinician.

Before the seminar, review pamphlets and books that are designed to help people quit smoking. The American Heart Association and the American Lung Association both publish numerous pamphlets. An excellent pamphlet, Calling it Quits, is available from the U.S. Department of Health and Social Services. If you are not experienced in methods of smoking cessation, you might benefit from attending a stop smoking group sponsored by a local hospital or voluntary organization.

PREPARATION OF THE RESIDENTS

The interested resident would benefit from reading, The Smoking Digest (1977). S/he would also acquire concrete suggestions for assisting the patient from patient pamphlets such as "Calling it Quits" or "How to Quit" (American Heart Association) which provide detailed instructions for smoking cessation.

SEMINAR OUTLINE

I. Introduction

This seminar on smoking cessation is designed to answer the following questions:

A. What physiological effects of smoking, when presented to a patient, will convince that patient to quit smoking?

B. Why do people smoke? Why is it that so many people are unwilling to even consider stopping?

C. What is it like for a smoker to stop?

D. How do you introduce the topic of smoking cessation with a patient?

E. How can you, in a limited period of time, help a patient quit smoking?

II. Using Information To Help People Stop Smoking

A. In presenting information to people, choose information that the patient finds personally relevant.

Although most smokers know that smoking causes lung cancer, few give up smoking for that reason. The few that do are likely to have recently witnessed the death of a relative or friend due to lung cancer.

An individual who is concerned about the effects of smoking on health will probably be impressed with the immediate effects of cigarette smoke. The following information was taken from pages 17 and 18 of The Smoking Digest. Cigarette smoke contains carbon monoxide, tar and particulates, and nicotine, among other ingredients.

1. Carbon monoxide, familiar as a poison to most people, represents 1-5% of cigarette smoke, but is converted to 2-15% carboxyhemoglobin in the blood of a smoker, compared to 0.5-2% for a nonsmoker.

   a. Carbon monoxide leads to damage in the walls of the arteries.
   b. Carbon monoxide inhalation greatly decreases the availability of oxygen to the heart, decreasing endurance while increasing the probability of heart attacks and sudden death.
   c. Carbon monoxide greatly increases the risk of damage to the fetus for pregnant mothers.

2. Nicotine, also a poison, is a stimulant that increases heart rate and blood pressure and increases the body's need for oxygen at the same time that oxygen availability is decreased by breathing carbon monoxide in smoke.

3. Tars and particulates in smoke may be carcinogenic, but also coat the cilia in the bronchial tract with a brown, sticky coating. This decreases the ability to move mucous out of the lungs and increases the body's susceptibility to infection.

    These effects of cigarette smoke can be seen in the young children of smokers who have more frequent respiratory infections than the children of non-smokers.

B. If you use information to scare people about the effects of smoking, make sure you also provide ways of reducing the threat.

    1. If an individual stops smoking, the effects of carbon monoxide stop immediately, and with that, the death rate from sudden death, heart attacks.

    2. There is a slower but steady recovery of the action of the cilia moving mucous.

    3. Ten years after stopping, a smoker of 1-19 cigarettes per day is at no greater risk than a non-smoker.

C. Personalized information is most effective. The pregnant smoker is more impressed by information about the effects of smoking on her fetus than by information about heart disease and cancer. The patient with repeated upper respiratory infections may need to hear from the physician that these infections may be related to smoking and would certainly decrease in frequency if s/he were to stop.

III. Using Personal Experiences to Help People Stop Smoking

1. Most people who want to stop smoking have probably tried to stop before, even if just for an hour. Although the patient may view this as a failure, it can be used as a learning experience. In helping someone quit smoking, it is important to learn about past attempts, how long they were successful, why the patient went back to smoking.

2. The smoker can build on past experiences to plan strategies for quitting. Those same factors which caused problems initially are likely to cause problems again. The smoker may be able to handle difficult situations by anticipating problems and devising coping strategies.

IV. Why People Smoke. Why Quitting May Be Difficult:

A. Ask residents to discuss reasons they believe people smoke. The following reasons have been identified by smoking researchers (Horn, 1979).

    1. People smoke for a sense of increased energy or stimulation. Some people smoke while studying or driving to keep alert or awake.

2. People smoke for the satisfaction of handling or manipulating things. Some people keep their hands busy by smoking cigarettes.

3. People smoke for the accentuation of pleasure and relaxation. Smoking can be perceived as an enjoyable pastime; smoking a cigarette with a cup of coffee or a glass of beer, and smoking with a friend after work are examples of this type of smoking.

4. People smoke as a means of reducing feelings of anxiety or anger. Some people light up whenever they become upset.

5. People smoke because they are psychologically addicted to cigarettes. Such people crave the next cigarette as soon as they have finished the last one.

6. Some people smoke out of habit, often lighting and smoking a cigarette without being aware of it, or even consciously deciding to do so.

Some or all of these reasons are important to smokers and provide powerful motivation to continue smoking.

B. Personal experiences with smoking. Discuss the resident's personal experiences:

1. Did they smoke?

2. When did they quit?

3. Why did they quit?

4. How did it feel?

5. Was it difficult?

C. A physician's experience with quitting:

An interview with a 32-year-old physician who had quit smoking four days earlier follows this seminar (see Appendix). He had stopped smoking before, for two years during medical school, and briefly during his residency. He describes how personal, rather than health factors, motivated his quitting, and how difficult the process of withdrawal is for him.

V. Changing Personal Behaviors

Ask the residents to look at some of their own habits or things they do regularly in order to gain more insight into reasons people continue to smoke (or overeat, or drink), along with specific strategies for helping patients change their behaviors.

A. Take the next several minutes to think of something that you do regularly that would be hard to give up. The behavior does not have to be one that you consider bad or unhealthy. Simply identify something that would be hard to give up, something that you do frequently, or on a regular basis. (If the residents have a hard time identifying a behavior, the following examples could be used.) These are behaviors which residents at the University of Wisconsin identified:

1. Jogging
2. Playing basketball
3. Chewing on toothpicks
4. Drinking coffee
5. Eating meat
6. Brushing teeth

B. After everyone has chosen a personal behavior, talk about each person's choice, using the following kinds of questions:

1. What did you choose?
2. What do you get out of doing it?
3. What would convince you to give it up?
4. How would you want someone to approach you about giving it up?
5. How easy or hard would it be?
6. What would be hard about it?
7. Have you ever tried to give it up?
8. What happened?
9. How do you think you would feel?
10. What kind of problems would you have?
11. In what kind of situations would you have the most difficulty sticking to your decision to give it up?
12. What would be of help to you when you were having trouble sticking to your decision?
13. What would you need to do in order to carry out your decision to quit?

14. What do you think you might substitute for that behavior, if anything?

15. How do you feel now when you aren't able to __________?

16. What negative consequences would you anticipate from giving up __________?

17. How would your family or friends respond?

18. How would they help or hinder your change?

C. There are several ways that a resident's answers can be compared and contrasted with smoking behavior. Two alternatives for leading this discussion are:

1. Ask about each resident's behavior, using the questions listed above. While going through this list, point out similarities between the resident's behavior and smoking behavior (see discussion of smoking behavior that follows). For example, faced with the prospect of giving up basketball, one resident said he would switch to cycling in order to continue getting enough exercise. Similarly, smokers switch to lower tar and nicotine cigarettes in order to continue smoking while also reducing the threat that smoking poses to their health. Another resident said that she feels jumpy if she is not able to run or jog every day. Smokers are also likely to notice sensations when they stop, including headache, irritability, muscle aches and anxiety.

2. Ask about each resident's behavior using the questions above. In the discussions of smoking behavior which follows, point out parallels with residents behaviors.

VI. The Primary Care Physician's Role in Smoking Cessation

A. Introducing the topic of smoking cessation.

Although it is clear that simply giving information does little to change behavior (people smoke despite knowledge about lung cancer threat), avoiding or ignoring the topic can be interpreted by patients as condoning smoking. In fact, physicians can play an important role. In a British study of heavy smokers, one half quit after only an examination and three counseling sessions by a physician (see The Smoking Digest, 1977). Because most smokers attempt at some time to quit smoking, physicians should identify themselves as resources for assistance when that decision is made.

The physician is also in a unique position to take advantage of precipitating events in patient's lives. Serious illness such as pneumonia, heart attack or cancer in the patient's family, might provide the patient with an immediate reason to reduce or quit smoking.

B. Assisting smokers who have decided to quit.

1. Ask residents: What sort of approaches have you used in assisting smokers to quit? The following should be covered:

   a. Use existing materials - "Helping Smokers Quit" Kit, Box 61, National Cancer Institute, Bethesda, MD 20205.
   b. Using existing community resources. The following groups can be contacted to identify resources in specific communities: (from Danaher et al. 1980, p. 120).

American Cancer Society
777 3rd Avenue
New York, NY 10017

American Heart Association
7320 Greenville Ave.
Dallas, TX 75231

American Lung Association
1740 Broadway
New York, NY 10019

General Headquarters
5 Day Plan to Stop Smoking
Seventh Day Adventist Church
Narcotics Education Division
6840 Eastern Ave., NW
Washington, DC 20012

Office of Cancer Communications
National Cancer Institute
National Institutes of Health
Bethesda, MD 20205

Office on Smoking and Health
U.S. Department of Health and Human Services
200 Independence Ave., SW
Room 622E
Washington, DC 20201

National Interagency Council on Smoking and Health
419 Park Avenue South
Suite 1301
New York, NY 10016

Schick Laboratories
1901 Avenue of the Stars
Suite 1530
Los Angeles, CA 90067

SmokeEnders
Memorial Parkway
Phillipsburg, NJ 08864

C. Doing individual counseling. If the physician wishes to assist the patient to quit smoking, s/he should become acquainted with the methods suggested by smoking behavior specialists. Residents should be encouraged to read a general introduction to the problem, such as Danaher et al. (1980). The authors suggest the following strategies:

1. Assess the individual's reasons for smoking;

2. Identify individual smoking patterns, using a smoking diary, without actually reducing the number of cigarettes smoked;

3. Prepare the patient for withdrawal from smoking by anticipating problems (e.g., weight gain, social pressure to smoke, nicotine withdrawal sensations) and providing ways of coping with them; e.g., relaxation exercises, diet changes;

4. Draw up a written contract with the patient, including a target quit day, and a follow-up clinic visit within 1-2 weeks;

5. Review some concrete benefits of cessation, e.g., less heart attack risk, more enjoyment of foods, fresher breath, fewer coughs over the long run, more stamina;

6. Reassure the smoker who fails to quit that many do not succeed at first, and encourage the smoker to attempt again when s/he feels ready.

D. As a summary, discuss the following guidelines for suggesting behavior change.

1. Present information which the patient will find personally relevant.

    Example: "Smoking will cause premature wrinkling of the skin." Do not say, "Smoking will cause lung cancer."

2. If you use information to frighten your patient, also provide the patient with clear and effective ways of reducing the threat.

    Example: "Because of your heart disease your smoking may kill you, BUT if you stop, the risk of sudden death will immediately decrease dramatically. This is because you will no longer experience the effects of carbon monoxide and nicotine in your system. Strategies for stopping include. . ."

3. Instructions should be as clear and specific as possible.

    Example: "Begin by cutting out the cigarettes you enjoy most, such as the ones you smoke while you are drinking coffee or after a meal. Which cigarettes will you choose to cut out?"

4. Identify a goal which the patient is sure to be able to accomplish (nothing succeeds like success).

   Example: "The first week, keep a record of each cigarette you smoke in this smoking diary."

5. Identify immediate benefits of changing behavior.

   Example: "You will have a stronger sense of taste within one week after quitting."

OBSERVATION AND FEEDBACK ACTIVITY FOR MODULE 4

The primary goals of this observation and feedback activity are to review each resident's progress in integrating patient education skills into clinical practice and to develop an individualized educational plan for each resident who has not yet mastered the skills taught in the first three modules. A secondary goal of this activity is to assist the residents who have mastered previously-taught skills to increase skill in performing the behaviors described in criterion A.8.:

> Were health promotion activities assessed and reinforced/ encouraged (immunizations, diet, smoking, safety, breast self-examination)?

This observation and feedback activity is scheduled to take place at the very end of Module 4 in order to allow each resident sufficient time to use Module 3 feedback suggestions for improving skills before being observed again.

PREPARATION OF THE OBSERVER

Carefully read all of the Module 4 materials in this manual. Pay particular attention to the "Discussion of Module 4 Objectives" and "The Role of the Clinical Faculty for Module 4." These materials provide specific examples, a logical justification and references to relevant research studies for patient education strategies for health promotion. Also, review the entire "Justification of Criteria," (pages 41-59).

Read about techniques of enhancing effectiveness of physician-patient communication. Ley (1977) presents research studies which have specific implications for increasing patient recall of information presented in a medical encounter. Podell (1976) discusses the effect of physician behavior on patient compliance and makes recommendations for preventing patient noncompliance. For an overview of behavioral self-control, including a discussion of research studies and implications for practice, see Mahoney and Thoresen (1974).

Review of residents skills and deficits. During Module 4 observations and feedback, particular attention is paid to each resident's performance of the observation protocol criteria which s/he had not mastered at the time of the Module 3 Observation and Feedback Activity. Before starting Module 4 observations, identify those criteria for each resident. For each resident, review all filled-out observation and feedback protocols from earlier observation and feedback activities. Scan the "No" column of the "Behavior Checklist" section of the observation protocol. Make a list of any criteria that were consistently checked "No."

For example, examine the sample Behavior Checklists of Observation Protocols for Dr. Jones on page 157. For the Module 1 observation, half of the Section A criteria are checked "No"; for the Module 3 observations, most of the Section A criteria are checked "Yes." Thus, it is readily apparent

SAMPLE: BEHAVIOR CHECKLISTS FOR DR. JONES

Module 1

BEHAVIOR CHECKLIST	Yes	No	N/A
A. Basic Communication & Assessment			
1. Did resident explore patient's [✓ concerns]/[✓ reason(s)] for visit?		✓	
2. Did resident ask open-ended questions?		✓	
3. Did resident ask about self-treatment prior to clinic visit?		✓	
4. Were the effects of ongoing therapy monitored? (effectiveness/[✓ problems])	✓		
5. Did resident use words patient could understand?	✓ &	✓	
6. Did resident tell patient what s/he was doing/[✓ examining]?	✓		
7. Did resident tell patient what s/he was finding?	✓		
8. Were health promotion activities assessed and reinforced/encouraged (immunizations, diet, smoking, safety, breast self-exam)?		✓	
B. Negotiation			
1. Did resident [✓ encourage]/respond appropriately to patient questions?		✓	
2. Did resident present information consistent with patient's needs (content/[✓ amount])? too much		✓	
3. Did resident justify regimen to patient?		✓	
4. Did resident prepare patient for symptoms/sensations?		✓	
5. Were alternative treatment plans discussed with patient?		✓	
C. Planning			
1. Was advice [✓ specific]/concrete?		✓	
2. Was patient provided with written instructions?	✓		
3. Was patient asked to demonstrate understanding of plan (physically/verbally)?		✓	
4. Were criteria or [✓ times] set up for [✓ follow-up]/call-in?	✓ &	✓	
5. Were supplemental referrals/resources used appropriately? ([✓ handouts], audio-visuals, other staff, commercial groups)	✓		
6. Did resident repeat conclusions/instructions at end of visit?		✓	

Module 3

BEHAVIOR CHECKLIST	Yes	No	N/A
A. Basic Communication & Assessment			
1. Did resident explore patient's [✓ concerns]/[✓ reason(s)] for visit?	✓		
2. Did resident ask open-ended questions?	✓		
3. Did resident ask about self-treatment prior to clinic visit?	✓		
4. Were the effects of ongoing therapy monitored? (effectiveness/problems)			✓
5. Did resident use words patient could understand?	✓		
6. Did resident tell patient what s/he was doing/[✓ examining]?		✓	
7. Did resident tell patient what s/he was finding?	✓		
8. Were health promotion activities assessed and reinforced/encouraged (immunizations, diet, smoking, safety, breast self-exam)?		✓	
B. Negotiation			
1. Did resident [✓ encourage]/respond appropriately to patient questions?		✓	
2. Did resident present information consistent with patient's needs ([✓ content]/[✓ amount])? yes no	✓ &	✓	
3. Did resident justify regimen to patient?		✓	
4. Did resident prepare patient for symptoms/sensations?		✓	
5. Were alternative treatment plans discussed with patient?		✓	
C. Planning			
1. Was advice [✓ specific]/concrete?	✓		
2. Was patient provided with written instructions?	✓		
3. Was patient asked to demonstrate understanding of plan (physically/verbally)?		✓	
4. Were criteria or times set up for follow-up/call-in?	✓		
5. Were supplemental referrals/resources used appropriately? ([✓ handouts], audio-visuals, other staff, commercial groups)	✓		
6. Did resident repeat conclusions/instructions at end of visit?	✓		

Module 3

BEHAVIOR CHECKLIST	Yes	No	N/A
A. Basic Communication & Assessment			
1. Did resident explore patient's [✓ concerns]/[✓ reason(s)] for visit?	✓		
2. Did resident ask open-ended questions?	✓		
3. Did resident ask about self-treatment prior to clinic visit?	✓		
4. Were the effects of ongoing therapy monitored? ([✓ effectiveness]/[✓ problems])	✓		
5. Did resident use words patient could understand?	✓		
6. Did resident tell patient what s/he was doing/[✓ examining]?	✓		
7. Did resident tell patient what s/he was finding?	✓		
8. Were health promotion activities assessed and reinforced/encouraged (immunizations, diet, smoking, safety, breast self-exam)?		✓	
B. Negotiation			
1. Did resident [✓ encourage]/respond appropriately to patient questions?		✓	
2. Did resident present information consistent with patient's needs (content/[✓ amount])? too much		✓	
3. Did resident justify regimen to patient?		✓	
4. Did resident prepare patient for symptoms/sensations?		✓	
5. Were alternative treatment plans discussed with patient?		✓	
C. Planning			
1. Was advice specific/concrete?	✓		
2. Was patient provided with written instructions?	✓		
3. Was patient asked to demonstrate understanding of plan (physically/verbally)?		✓	
4. Were criteria or times set up for follow-up/call-in?	✓		
5. Were supplemental referrals/resources used appropriately? ([✓ handouts], audio-visuals, other staff, commercial groups)	✓		
6. Did resident repeat conclusions/instructions at end of visit?	✓		

that Dr. Jones' basic communication and assessment skills improved between Module 1 and Module 3. It is equally apparent which skills Dr. Jones had not yet mastered at the time of the Module 3 observations, as all of the criteria in Section B as well as criterion C.3. are consistently checked "No." The observer reviewing Dr. Jones' file would then list the following criteria to focus on for Dr. Jones during the Module 4 Observation and Feedback Activity:

B. Negotiation

1. Did resident encourage/respond appropriately to patient questions?
2. Did resident present information consistent with patient's needs (content/amount)?
3. Did resident justify regimen to patient?
4. Did resident prepare patient for symptoms/sensations?
5. Were alternative treatment plans discussed with patient?

C. Planning

3. Was patient asked to demonstrate understanding of plan (physically/verbally)?

In addition to assisting each resident in improving skills for certain observation protocol criteria it may also be necessary to assist some residents to improve patient education skills in working with certain types of patients or patient problems. An examination of a resident's observation and feedback protocols may also identify situations in which residents have difficulty applying patient education skills. For example, a resident may have shown considerable skill in communicating with adults and a marked lack of skill in communicating with young children. Or, a resident may meet most of the criteria on the Behavior Checklist when working with patients who need routine check-ups or acute care. The same resident may not fulfill many of the planning criteria when working with a patient who has a chronic disease or multiple problems.

In summary, review observation and feedback protocols from past observation and feedback activities for each resident. Use these documents to identify each residents deficits including:

1. Deficits in general performance of certain observation protocol criteria.
2. Deficits in performance of observation protocol criteria with certain types of patients or patient problems.

PREPARATION OF THE RESIDENTS

Before starting Module 4 observations, meet with each resident in order to accomplish the following tasks:

1. Explain that the primary goals of this activity are to:

    a. Review each resident's progress at integrating previously-taught patient education skills into clinical practice.
    b. Assist each resident to develop an educational plan to improve patient education skills as needed.

2. Ask resident to use the observation protocol criteria to indicate patient education skills s/he has mastered, and which s/he needs to improve.

3. Ask resident to describe any types of patients or patient problems with which s/he needs help.

If a review of a resident's past performance and a resident's self-assessment indicate that the resident has mastered previously-taught skills, also discuss the following:

1. The secondary goal of this activity is to assist residents in developing patient education strategies for risk reduction.

2. Suggest that the resident prepare for this activity by thinking about the following questions:

    a. What does "health promotion" and "risk reduction" mean to you?
    b. What issues do health promotion and risk reduction include?
    c. What do you believe your role is vis à vis health promotion and risk reduction?
    d. What do you believe the patient's role is vis à vis health promotion and risk reduction?
    e. At what times do you introduce health promotion and risk reduction topics?
    f. How do you introduce health promotion and risk reduction topics?

INSTRUCTIONS FOR OBSERVATION AND FEEDBACK ACTIVITY

Follow the instructions which are given in the "Observation and Feedback Procedure" pamphlet in order to:

1. Schedule observation and feedback sessions.
   N.B. Visits for acute problems and visits for recently diagnosed chronic illness should not be used for Module 4 observations. A patient's agenda for these visits is to address specific problems and concerns. It is thus difficult for a physician to shift the agenda to health promotion topics. Well child care visits, pap and pelvic examinations, routine physical examinations and follow-up visits for infections or minor injuries provide more opportunity for a physician to discuss health promotion.

2. Observe each resident for at least three encounters.

3. Fill out an observation protocol for each encounter.

4. Prepare written feedback for each encounter.

5. Give each resident verbal and written feedback for each encounter.

When filling out the observation protocol:

1. Fill out the entire Behavior Checklist.

2. Record under "Examples":

    a. Resident statements and behavior which are connected to the list of observation protocol criteria which you and/or the resident identified as deficit areas.
    b. Resident statements and behavior which are connected to criterion A.8.:

    > "Were health promotion activities assessed and reinforced/encouraged (immunizations, diet, smoking, safety, breast self examination)?"

    See discussion below for more specific instructions.

Unlike the other criteria which specify a behavior only, the health promotion criterion specifies a content area as well as a group of behaviors. All of the criteria describing communication and basic patient education skills, negotiation skills and planning skills are needed in order to assess, reinforce and encourage health promotion activities in a competent manner.

Specific Instructions for Health Promotion Criterion

There are several components to consider when assessing a resident's performance of criterion A.8.:

1. If and how the criterion is applicable to the visit that is observed.

2. If and how a resident assesses a patient's interest and involvement in health promotion activities.

3. If and how a resident encourages a patient's involvement in health promotion activities, and

4. If and how a resident reinforces a patient's involvement in health promotion activities. In order that these four tasks be performed in a competent manner, the skills described in all of the criteria on the Behavior Checklist must be used: communication and basic patient education skills, negotiation skills and planning skills.

Applicability of health promotion criterion. The table below identifies health promotion topics that are applicable to specific types of patient encounters.

Encounter	Health Promotion Topics
School physical examination	Contraception, Exercise, Diet, Smoking Alcohol and Drug Use
Prenatal Visit	Alcohol and Drug Use, Diet, Smoking, Exercise, Breast Self-Examination
Well Child Care	Safety, Diet, Development, Relaxation, Immunizations
Pap and Pelvic	Contraception, Breast Self-Examination
Premarital Examination	Contraception, Breast Self-Examination
Chronic Illness	Smoking, Diet, Exercise, Relaxation
Follow-up for Minor Injury or Infection	Exercise, Smoking, Diet

It is not appropriate at times to introduce health promotion topics in the preceding types of encounters. Such times are: when a patient is given a great deal of information; when a patient is given stress-producing information; or when a patient is asked to start a new regimen which requires a behavior change. Under these circumstances the patient is unlikely to be able to focus either energy or attention on additional information about potential behavior changes.

Assessing a patient's interest and/or involvement in health promotion activities. Before encouraging a patient to become involved in health-related behavior change, such as an exercise program or a change in diet, a physician should determine what a patient is already doing. If the patient is not currently involved in the activity, it is important to determine if the patient is interested in changing her or his behavior. Patients have the ultimate responsibility and control over their actions. It is not a productive use of time to develop a plan for behavior change for an unwilling patient. In order to fulfill this component of the health promotion criterion adequately, a resident will need to explore a patient's concerns by asking open-ended questions; e.g., How much do you exercise? Do you have any interest in exercising more?

Encouraging a patient's involvement in health promotion activities. There are several strategies that are helpful for encouraging a patient to change behavior. When a patient is given information that is frightening; e.g., "Because you smoke, heart disease is more likely to be fatal", it is also important to give the patient clear and specific information concerning what to do about the threat, e.g., "If you stop smoking the risk of sudden death will immediately decrease. Let's talk about some effective methods for quitting smoking..." This strategy requires a justification of the proposed regimen, the provision of clear and specific advice, as well as a discussion of alternate treatment plans.

When encouraging a patient to adopt a health-related behavior, it is important to describe an immediate benefit of doing so in terms that are closely linked to the concerns of that patient. A patient who does not feel vulnerable to a threat such as lung cancer is not likely to change a longstanding habit to reduce her or his vulnerability to that threat. A patient who has just watched a close relative die of lung cancer is more likely to quit smoking due to a fear of lung cancer because the threat is more immediate.

A patient is likely to see immediate and personally relevant benefits of quitting smoking when told that smokers:

1. Feel more tired than non-smokers;

2. Often get more respiratory infections;

3. Are more short of breath;

4. Have bad breath.

The benefit of any proposed activity should be clearly stated. This is another way of saying: "Justify the treatment plan." A patient who does not understand the reason for an activity is not likely to follow through. An example is: "If you get at least 15 minutes of vigorous exercise a day, you will feel more relaxed, and sleep better."

Reinforcing a patient's involvement in health promotion activities. It is important to reinforce a patient for health promotion activities the patient is already engaged in. Reinforcement consists of making a positive comment and stressing the importance of the activity. "I'm glad you use a car seat for your baby. The greatest danger for a baby is an injury from an auto accident; car seats greatly reduce the chances of any harm to your baby."

After a patient is encouraged to incorporate new behaviors, it is important to help the patient develop a plan to follow through. Physicians are more effective when they present themselves as resource persons rather than as authority figures. Offering a patient alternatives for carrying out a plan allows the patient to choose the alternative for which s/he is best suited. ("People smoke for different reasons, so different ways of quitting work for different people. Some of those ways are..."). Clear and specific instructions should be offered for the alternative a patient chooses. For example, a patient who decides to taper down slowly the number of cigarettes smoked per day might be advised: "Begin by cutting out the cigarettes you smoke most. For example, eliminate the cigarettes you smoke while drinking coffee or when you have just finished a meal."

Supplemental handouts often provide an excellent source of strategies for carrying out health promotion activities. A patient can be given pamphlets or referred to books which offer helpful advice.

When a patient is encouraged to start a health promotion effort such as an exercise program, it is important to help the patient get short-term, attainable goals. Quick and observable success helps to promote a continuing effort. A patient who tries to walk 15 minutes a day for one week has a better chance of success than a patient who tries to jog five miles a day for a month. Short-term goals also make the treatment plan seem more feasible. It is much more encouraging to think of a weight loss program in terms of two pounds a week for ten weeks than it is to think of a 20-pound weight loss.

Behavior change is difficult and it takes a long time to complete. A physician can reassure a patient that difficulties can be overcome by sharing personal experiences. "I quit smoking five times before I finally found a method that worked. Each time I started smoking again, I tried to understand _why_ so I could find a method of quitting that worked for me."

A physician can also use personal experiences and experiences of other patients to help a patient solve any problems with a plan. A patient who has trouble finding a regular time to exercise might be told: "I, too, found it helpful to incorporate exercise into my daily routine. I found it helpful to exercise while watching the evening news, which is something I do every night."

WHEN PREPARING FEEDBACK

Choose for positive comment a resident's statements and behaviors which demonstrate that the resident has improved any skills which were not evident during the observation and feedback activities in Modules 1 and 3. Also, reinforce any skills a resident exhibits in the performance of the health promotion criterion.

If a resident has sufficiently mastered the skills taught in Modules 1 and 3, make suggestions for the resident's improvement of skills pertaining to the health promotion criterion.

1. Label the behavior you wish to discuss.

   Example: "You used information to frighten the patient, but gave no clear instructions for dealing with the threat you described."

2. Cite a specific example of the behavior from the encounter.

   Example: "You said you are very likely to get breast cancer. You should examine your breasts regularly so any cancer can be detected early, before it spreads throughout your body."

3. Justify the importance and the impact of the behavior.

   Example: "She told you that she does not feel capable of adequately examining her breasts. So, she is likely to be frightened, and at the same time, not examine her breasts. She may have no idea of what regularly means, since you didn't give her a specific idea of how often "regularly" means.

4. Give a specific suggestion for change for each skill that you want the resident to improve.

   Example: In order to follow your recommendations, she needs:

   a. Specific instructions for breast self-examination. You could demonstrate the process and have her practice in front of you. That way she would know that she's doing it right.
   b. A plan for incorporating breast self-examination into her routine which specifies what "regularly" means.

   Example: "How about doing it the first day of every month or on a pay day. The most important thing is that you do it regularly enough so that you know what your breasts usually feel like. Then you would notice if anything felt different, and you could come to the clinic to be checked."

Refer to the readings cited in "Preparation of the Observer" (page 156) and "Specific Instructions for the Health Promotion Criterion" (page 160) for assistance in identifying a rationale or example for feedback.

During verbal feedback regarding the health promotion criterion, stress the connection between the behaviors you discuss and the material presented in the Module 4 Seminars and the weight loss audit activity. Show the resident the need to use all of the skills taught in Modules 1-3 in order to discuss health promotion with a patient effectively. You may also suggest that a resident read, "Specific Instructions for the Health Promotion Criterion" (page 160), the "Justification of Criteria" (page 41), or the Module 4 "Discussion of Objectives" (page 145) and "The Role of the Clinical Faculty for Module 4" (page 178). In addition, Thoresen and Mahoney's short book, "Behavioral Self-Control" provides a detailed discussion of methods which assist patients to monitor and to change health behaviors.

A resident's performance in observed encounters may indicate that the resident has not yet mastered the skills taught in Modules 1-3. Using the format for feedback, identify the deficits and make specific suggestions for change. Do not give the resident feedback on the health promotion criterion because this could result in overloading the resident with suggestions for change.

Work with a resident to develop an individualized plan to remedy existing skill deficits. Make a list of deficits. Develop a plan for each deficit which identifies specific behaviors the resident will practice, people who will be involved in the plan, and strategies that will be used to assist the resident. Specify a time at which the resident's progress will be reviewed. A plan can involve faculty physicians, nurse clinicians, behavioral scientists, relevant readings and community resources. See page 165 for examples of skill deficits and follow-up plans.

Skill Deficit	Follow-up Plan
Resident does not assess patients' reasons and concerns for visit.	Resident will explicitly assess each patient's reasons and concerns for the visit for one week. Resident will record this information in each patient's chart. Resident will compare information noted in the appointment book and the information gathered by talking with each patient. At the end of the week, resident will be again observed to assess progress.
Resident uses medical terminology without assessing patient's understanding.	Resident will make a conscious effort to use as few technical terms as possible. Resident will use lay language to explain any technical terms or concepts he uses. Resident will assess patient understanding of any technical terms or concepts used with questions such as: "What is your understanding of ___?" "What does this mean to you?" "How would you explain your condition to your wife?" Nurse clinician will perform one exit interview per day of resident's patients for one week. Nurse clinician will give resident feedback for each exit interview, identifying terms and concepts a patient had difficulty with.
Resident does not rehearse plans with elderly patients. (The observer suspects that the patients do not understand the plans.)	Resident will accompany faculty physician on nursing home rounds for one month. Resident will be observed during encounter with elderly patient at end of month.
Resident does not respond to questions from parents during well child visits. Observer believes that the resident needs more information and experience in the area of child development.	Resident will read Parents and Children by Brazelton. Resident will cross schedule all well child visits with pediatric nurse clinician for one month. Resident will spend two mornings at a day care center to observe the behavior of normal children. Resident will be observed during a well child visit at the end of the month.

Instructional Modules to Teach Primary Care Residents to Educate Patients, by
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WEIGHT LOSS CHART REVIEW AND FEEDBACK
ACTIVITY FOR MODULE 4

Because overweight is a health risk common to many patients, weight loss is a health promotion topic that is frequently addressed by physicians. The medical record renders information about methods used to help a patient lose weight in addition to documenting fluctuations in a patient's weight. For this activity, a structured protocol is used to collect data systematically from the medical records of each resident's overweight patients. The protocol criteria reflect strategies which are useful in developing a long-term plan for weight loss.

The protocol criteria and data from the medical records of a resident's overweight patients are discussed in individual meetings with each resident. Residents are encouraged to examine alternative strategies for assisting patients in weight loss and other long-term behavior changes.

OBJECTIVES

The resident will discuss:

1. Strategies s/he uses to assist patients in losing weight;

2. Alternative strategies for weight loss and other long-term behavior changes.

PREPARATION OF THE CHART REVIEWER

The major preparation task for this activity consists of identifying and reviewing charts of each resident's overweight patients. There are several methods of identifying appropriate charts for review. If a computerized problem list is kept for residency clinic patients, a computer search can be used to generate a list of each resident's overweight patients. The daily appointment books kept by clinic receptionists will yield names of patients who make appointments for weight checks or diet counseling. Finally, each resident can be asked to make a list of patients s/he sees for weight counseling. Further instructions for identifying charts to review are given in the "Instruction Pamphlet for the Weight Loss Chart Review" (page 186).

Either a research assistant or the patient education faculty member can use the Instruction Pamphlet to review charts and collect data. The faculty member would then discuss the data during an individual meeting with each resident. Alternatively, the faculty member could review one or two patient charts with each resident, recording and then discussing the data. This method requires more resident time, as approximately 10-20 minutes is required to review one patient chart. However, a resident would then have the opportunity to discuss the patient whose chart is reviewed in greater detail. If charts are to be reviewed before meeting with the residents, the chart review process should be initiated two weeks to one month before the meetings are scheduled. This will ensure that the data are collected before the meetings take place.

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The number of charts to review for each resident is at the discretion of the faculty member. A review of one or two charts per resident is sufficient to discuss the strategies involved in weight loss. A review of five or ten charts will reveal a pattern of strategies that each resident uses when helping patients lose weight.

The faculty member who conducts the feedback activity with the resident should carefully review the following outline and be familiar with the chart review form and the justifications for the chart review criteria.

I. Describe and Justify Chart Review Process to the Resident

A. Chart review criteria will be reviewed.

B. The resident's charting will be discussed (either the results of charts reviewed prior to activity, or charts reviewed with the resident during the activity).

C. Documentation of weight loss plans is essential to efficient and effective patient education.

1. Avoids repetition.

2. Identifies gaps in knowledge/assessment/plans.

3. Improves follow-up.

II. Discuss Chart Review Criteria
(Show sample form, Appendix II, page 194). Refer, if necessary, to the "Justification of Criteria" which follows this outline.

A. The following criteria were chosen as tasks which should be performed and documented at each visit. (Expected frequency of performance: All visits). These include:

1. Weight.

2. Small interim goal for weight loss set.

3. Compliance with previous plans assessed.

4. Follow-up visit set (not PRN).

5. Weight mentioned at each visit.

B. A second set of criteria should be performed and documented at some point during planning and treatment. (Expected frequency of performance: 1).

1. Final goal set.

2. Past attempts at weight loss assessed.

3. Family support assessed.

4. Daily eating habits assessed.

   a. By patient diary.
   b. By 24 hour recall.

C. A third set of criteria should be performed and documented at least once. (Expected frequency of performance: 1+):

   1. The patient's desire to lose weight is assessed.

   2. Written instructions are given (regarding weight loss).

   3. A behavioral plan is established.

   4. The patient is given information about calories and about how to lose weight.

D. Ask resident:

   1. Can these criteria reasonably be recorded in the chart? Do you disagree with any criterion on its expected frequency?

   2. Which do you perform? Which do you record?

   3. Any others? (e.g., establish contract, reinforce weight loss, etc.)

E. If conducting the review with the resident, use the chart review forms to review available charts following instructions in Appendix II (page 186.

F. Present and discuss the resident's chart review results.

   1. For example, using the sample completed chart review (page 173, the following information could be used to reinforce good current charting and to make suggestions for improvements:

      a. Weight was recorded at each visit.
      b. Weight was mentioned in 3 of 4 visits. (An opportunity was missed on 6/3/80).
      c. Baseline data was recorded for most categories requiring only a single assessment (exception: family support).
      d. No notes were found on the criteria requiring at least one assessment.

   2. Discuss and plan educational strategies to be used at subsequent visits to meet gaps identified by reviews. From the sample chart review the plan might include:

      a. Next visit: set an interim goal; assess patient's desire to lose weight; provide written weight instructions and set follow-up visit.

   b. Subsequent visit: make a behavioral plan; give printed information to the patient, etc.

3. If several charts are audited, patterns in the resident's charts can be identified:

   a. For example, if the baseline data is usually recorded for several patients, but few interventions are documented, discuss the importance of working out and documenting plans.

   b. If baseline data is not usually recorded, begin by discussing the importance of assessing and documenting these factors prior to planning the treatment. Suggest follow-up chart review to determine progress.

G. Summarize strengths and weaknesses of resident's charts as reviewed. Suggest the review of appropriate Module 4 readings or other materials as needed.

JUSTIFICATION OF CRITERIA

DATA

Was Final Goal Set and Noted?

Setting a goal helps the patient identify progress and gives both the patient and the physician a way to evaluate success. Asking, "How much did you weigh when you were 18 or when you got married?" helps people set goals which are realistic. The goal should be recorded in the chart for future reference.

Were Short Term Goals Set?

Setting short term goals provides the patient with realistic expectations about weight loss for subsequent visits with immediate feedback about her or his success. Initial success encourages the patient to stick to the plan. Goals of not more than 1-2 pounds per week are reasonable and achievable for people who can eliminate 500 calories per day from their daily consumption. Specific behavioral goals, such as "eliminate bedtime snacks" are also an important step in weight loss. On follow-up visits, comparing current weight to the short term goal weight provides specific criteria for praising the patient, and a guide for setting the next realistic short term goal. This step by step method is more effective than focusing on reaching some distant final goal.

Past Attempts at Weight Loss

Asking about past attempts at weight loss gives insight into strategies which have worked for the patient and/or pitfalls to avoid. Asking, "How have you tried to lose weight in the past? How did it work for you? Where were your problems?" provides part of the baseline data necessary for developing a reasonable, workable plan. An initial documentation of these attempts can prevent needless repetitions at follow-up visits, and provides an explicit rationale for deciding on a particular plan.

Family Support

The quality and quantity of food consumed is significantly affected by those situations in which it is eaten. Family support can be assessed by specific questions such as:

> How does your family eat? Does anybody else have any eating problem?
>
> What does your family think of your dieting?
>
> Does your family (friends) tease you about your weight problems or when you overeat?
>
> Does your family (friends) encourage you verbally, but then offer you food, or use food as a token of affection?
>
> Does your family (friends) make it hard for you to stay on your diet by offering you high calorie treats or snacks?
>
> Does your family (friends) ignore your efforts at dieting?

A note about potential problems or sources of support can assist the patient and physician not only to devise plans to take advantage of support or work around problems, but also can serve to remind the physician to reassess family support of weight loss efforts.

Daily Eating Habits

Twenty-four hour recall uncovers many hidden sources of calories or situations in which the patient tends to overeat. For a 24 hour history ask:

> "Tell me about what you ate yesterday. Beginning when you woke up, when did you first eat? What did you eat? What did you eat next? What did you eat then? ..."

Tying eating to events of the day helps the patient remember snacks which would be forgotten if the question was, "What did you eat for breakfast ... lunch ... dinner?"

A 4 day eating diary (2 weekdays and 2 weekend days) will also provide important information about a patient's eating behavior. The patient should record:

How much s/he ate, and what s/he ate.
Times s/he ate.
What s/he was doing while eating.
How s/he was feeling when s/he ate.

Feelings and activities are often triggers for eating behavior. Some people eat when they are anxious; some snack in front of the television. A record in the chart of a patient's eating patterns will provide cues for intervention, and a source of comparative data at subsequent visits.

Was Compliance with a Diet Plan Assessed?

If a specific behavior plan was established at the previous visit, assessing compliance consists of reviewing the behaviors suggested. Without a specific plan, assessing compliance is more difficult. "Did you follow your diet?" seldom elicits useful information. Obtaining specific data about meals and snacks and how they were prepared will give you better data about adherence. Asking "When did you snack? What did you eat? What problems did you have following the plan?" provides information and justifies continuing or altering treatment plans. Assessing compliance also stresses the importance of the plan. Recording compliance at each visit provides an ongoing record of the utility of the plan and the problems or successes the patient is experiencing.

Desire to Lose Weight

For the non-compliant patient, desire to lose weight should be reassessed. Is the patient willing to change her or his behaviors? Are the patient's short and long term goals for weight loss realistic? Recording this assessment provides documented justification for treatment decisions, such as altering or abandoning a plan that is not being followed or postponing weight loss efforts until other problems are resolved.

INTERVENTION

Written Instructions

In complicated weight loss counseling sessions, written instructions at each visit serve to remind the patient of short term goals and the instructions the physician and patient have decided on. A note about those instructions in the chart serves as a reminder of what the instructions were, and can assist the physician to assess adherence at subsequent visits.

Behavioral Plan Established

A specific behavioral plan, negotiated between physician and patient, is easier to adhere to than general instructions like "Try to eat less." Examples of a behavioral plan are:

"Eliminate snacking while watching T.V."
"Only eat sitting down at the dining room table."
"Drink skim milk instead of whole milk."

Recording the plan in the chart can assist in assessing compliance at subsequent visits.

Patient Given Information about Calories, Weight Loss

Most patients lack information about appropriate nutrition and eating patterns. This information is a necessary part of treatment. Many books and pamphlets also provide hints for dieters. Recording when this information is given can provide opportunities for follow-up questions at the next visit, such as "What questions or problems did you have with the handout?"

Follow-up Visit Set (not PRN)

A specific follow-up date provides the patient with a limit on the time for goal achievement, and increases the likelihood that the patient will stay in treatment. A note in the chart on that date provides clear information on patient follow-through at each visit.

Mention of Weight at Visit

We feel strongly that the patient's weight should be addressed at all visits, even visits for a cold or ear infection. The patient interprets the doctors silence about weight at a visit as a message that her/his weight change is no longer important. We feel that it is important to reinforce weight loss or assess problems at each visit. A note in the chart can provide information between weight loss visits on how the patient's weight loss (or the treatment plan) is progressing.

SAMPLE

CHART REVIEW - WEIGHT LOSS

Patient *Martha Quest*

Chart No. *432-5334*

Age *30* Height *5'8"*

Resident Responsible *Lesing*

Date *8/3/80*

Visit date		5/31/80	6/3/80	7/8/80	7/20/80			
Main purpose of visit		Weight check	Cough	Weight check	Weight check			
M.D.		Holden	Lesing	Lesing	Lesing			
DATA:	Expected Frequency of Performance							
Weight	All	200	203	198	195			
Final goal set	1	+	0	0	0			
Small interim goals set	All	0	0	0	0			
Past attempts at weight loss assessed	1	+	0	0	0			
Family support assessed	1	0	0	0	0			
Daily eating habits assessed	1	0	0	+	0			
- By patient diary	1	0	0	+	0			
- By 24 hour recall	1	0	0	0	0			
Compliance assessed	All	0	0	+	+			
Patient desire to lose weight assessed	1+	0	0	0	0			
INTERVENTION:								
Written instructions (re: weight loss)	1+	0	0	0	0			
Behavioral plan established	1+	0	0	0	0			
Patient given information:								
- About calories	1+	0	0	0	0			
- About how to lose weight	1+	0	0	0	0			
Follow-up visit set (Not PRN)	All	+	0	+	0			
Mention of weight at visit	All	+	0	+	+			

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SEMINAR FOR MODULE 4

PANEL DISCUSSION: METHODS OF HELPING PEOPLE TO LOSE WEIGHT

The primary care physician is often unable to spend the amount of time that is required to assist a patient to lose weight. In such a case, a referral is indicated. If there is no one in the physician's practice who is available for weight loss counseling, the physician must refer to a community weight loss resource. But given the multiple resources that exist, how does the physician choose one? Which program will fit the needs of the patient? How do the programs differ? Which resources use proven methods of behavior change? In addition to giving patients information about diets, do the programs also assist patients to make long-term behavior change?

During the panel discussion, representatives of community weight loss programs are asked to describe their methods and philosophies of weight loss with the residents. Residents are then given an opportunity to ask questions of the panelists. During the second half of the seminar, the leader encourages the residents to evaluate the strengths and weaknesses of the various programs through a discussion of basic components of a weight loss program.

OBJECTIVES

The resident will:

1. Gather information about weight loss resources in the community;
2. Participate in a discussion of basic components of a weight loss program.

PREPARATION OF THE SEMINAR LEADER

In order to become familiar with the basic concepts of weight loss, read either Permanent Weight Control by Mahoney and Mahoney or Slim Chance in a Fat World by Stuart and Davis. Both books are easy to read and present the basic behavioral components of weight loss.

Three months before the seminar, invite panelists from three different types of community weight loss programs. Many communities have weight loss programs affiliated with Weight Watchers, Overeaters Anonymous, national chains of intensive weight loss clinics, hospital dietetics departments and county extension home economist offices.

If possible, invite a speaker from Weight Watcher's. One of the most widespread weight loss groups, Weight Watcher's, incorporates an excellent nutritional program with a long-term behavioral approach to weight loss. Overeater's Anonymous emphasizes peer support in an approach to weight loss that is similar to that of Alcoholics Anonymous. Recently, chains of intensive diet centers have appeared throughout the country. The programs of these diet centers consist of a severe reduction of caloric intake, daily follow-up and a major financial commitment on the part of the dieter. Hospital dietetics departments, the YWCA and county extension home economists often run weight reduction programs. Limit the panel to three speakers. This will give the speakers sufficient time to describe their programs and answer questions from the residents.

Meet with each speaker one month before the seminar. Explain that the purpose of the panel presentation is to enable the residents to make an informal choice of referral resources for their patients. Ask each speaker to prepare a ten to fifteen minute presentation that includes:

1. A description of the basic components of the program;

2. How the program helps people lose weight;

3. The cost and duration of the program;

4. The types of people for which the program seems to work best.

PREPARATION OF THE RESIDENT

Suggest that the resident prepares for the seminar by reading Permanent Weight Control by Mahoney and Mahoney, Slim Chance in a Fat World by Stuart and Davis, or other dieter's handbooks that discuss behavioral methods of weight control. These books will furnish the information necessary to analyze the strengths and weaknesses of the programs which are described during the seminar.

SEMINAR OUTLINE

I. Panel Presentation

   A. Introduce each speaker. State the amount of time allotted to each speaker (10-15 minutes).

   B. Announce that a question-and-answer period will follow the presentations and ask that residents save questions until that time.

II. Question-and-Answer Period

   A. After the formal presentation, encourage the residents to ask questions which will elicit information necessary in order to choose referral resources for their patients.

   B. At the end of the question-and-answer period, take a brief break, and give the panelists an opportunity to leave if they wish to do so.

III. Discussion (Use a transparency on an overhead projector or a blackboard)

A. Ask the residents to identify the strengths and weaknesses of the weight-loss programs described by the panelists as well as any weight-loss assistance currently provided by residents, nurses or behavioral scientists in the residency's clinic.

B. Draw the following diagram:

CHARACTERISTICS	PANELIST A	PANELIST B	PANELIST C	RESIDENCY CLINIC
1.				
2.				
3.				
4.				
5.				
6.				

C. Fill in this diagram during the discussion.

CHARACTERISTIC	PROGRAM 1	PROGRAM 2	PROGRAM 3	RESIDENCY CLINIC
1. Peer support	Strength	Strength	Weakness	Weakness
2. Individual teaching or counseling	Weakness	Weakness	Strength	Strength
3. Adequate long-term planning	Strength	Strength	Weakness	Strength
4. Application of behavioral principles	Strength	Weakness	Weakness	Weakness
5. Education about healthy eating habits	Strength	Weakness	Weakness	Strength
6. Incentive of financial commitment	Strength	Weakness	Strength	Weakness
7. Affordable cost	Strength	Strength	Weakness	Strength

D. At the end of the discussion draw on the principles of weight loss described by Stuart and Davis, or Mahoney and Mahoney, in order to add any characteristics the residents did not identify.

THE ROLE OF THE CLINICAL FACULTY FOR MODULE 4

A primary care physician sees many patients whose health has been seriously harmed by overeating, smoking, inattention to safety precautions and other health related behaviors. An acute awareness of the impact of destructive health habits and a commitment to patient well being may tempt a physician to demand that a patient adopt healthy behaviors. Although well intended, such a strategy rarely results in the desired outcome. In "My Style of Practice," Dr. Lloyd offers his perspective on this phenomenon:

> "We turn some off by focusing on what's important to us instead of listening to what is important to them... I think we have to identify the patient's priority system first and develop a trust relationship before we can truly be effective as healers or as helpers for patients. They will appreciate it if you do not aggravate their guilt system when they walk in the door."

An experienced physician is aware of opportune moments for discussing health promotion topics with patients and has developed effective strategies for reinforcing and encouraging health habits. Behavior change is a long-term process of incremental changes which is facilitated by continuing reinforcement and assistance from the health care team, the patient's family and community resources.

The activities in Module 4 are designed to teach the residents to:

1. Elicit accurate verbal reports of health related behaviors;
2. Introduce health promotion topics during patient visits in which other major behavioral changes, new problems, or treatment plans are not discussed;
3. Assess patient priorities for changing health related behaviors;
4. Respond to patient interest in health promotion with specific suggestions for behavior change;
5. Identify family members and friends who can assist the patient in changing health related behaviors;
6. Request that patients keep a diary of behaviors;
7. Assist the patient in choosing a referral resource.

METHODS OF TEACHING PATIENT EDUCATION SKILLS IN THE OUTPATIENT CLINIC

1. *Elicit accurate verbal reports of health related behavior.*

It is necessary to phrase questions about health related behavior carefully in order to elicit accurate responses. If a physician indicates that only one response is acceptable, that is the response s/he is likely to get. "You get proper nutrition don't you?" will, in most cases, elicit "of course" for an answer. A patient is more likely to provide accurate and useful information to open-ended and accepting questions such as: "What have you done so far to child-proof your house?" or, "What would help you to stop smoking?"

When you see a patient with a resident, assess the patient's health related behaviors by asking questions such as:

1. "Many people have a hard time figuring out what a healthy diet is. I'd like you to describe what you might eat on a typical day so we can be sure that you are getting the kind of nutrients that you need."

2. "How do you feel about smoking?"

3. "How do you drink?"

4. "Many women don't examine their breasts because they aren't sure they know how. What questions would you like to ask about it?"

5. "What problems do you have remembering to take the pill?"

These questions invite the patient to be open and to relate to a physician as a resource person. After hearing the self-disclosing responses of a patient to an open-ended and accepting question, a resident will see the value of interviewing in this manner.

When you discuss a patient with a resident, stress the importance of obtaining accurate responses and suggest methods of doing so. This will encourage the resident to examine the impact of her or his style of questioning.

2. *Introduce health promotion topics during patient visits in which other major behavioral changes, new problems or new treatment plans are not discussed.*

Patients remember only a limited amount of what is said during a medical visit and the amount of information patients remember decreases when the amount of information given increases. A substantial amount of information is given to a patient whenever major behavior changes, new problems, or new treatment plans are discussed during a visit. It is difficult to insert health promotion topics into the agenda of such a visit. It is also a futile endeavor because a patient will find it difficult to take in or recall this additional information. The type of visits which are usually conducive to the discussion of certain health promotion topics are as follows:

Encounter	Health Promotion Topics
School physicals	Contraception, Exercise, Diet, Smoking
Prenatal visits	Alcohol and Drug Use, Diet, Smoking, Exercise, Breast Self-Examination
Well child care	Safety, Diet, Development, Relaxation
Premarital examinations	Contraception, Breast Self-Examination
Chronic illness	Smoking, Diet, Exercise, Relaxation

You can help a resident identify opportune moments for introducing health promotion topics. For example, you might suggest that a resident discuss the impact of smoking and diet on blood pressure when a hypertensive patient sees the resident for a routine blood pressure check.

3. *Assess patient priorities for changing health related behaviors.*

Physicians and patients have different perspectives on health promotion. A physician is acutely aware of the impact of health related behaviors while often unaware of the difficulty of changing behavior. A patient is often unaware of the impact of health related behaviors while acutely aware of the difficulty of changing behavior. In order to assist a patient in adopting healthy behavior, the physician first identifies a patient's health risks, describing the benefits of reducing those risks. After presenting this information, it is important to ask the patient to identify which health topic s/he is ready to address. The physician and the patient can then work together to construct a plan to meet common goals.

It is true that this may be a frustrating process for a physician when a patient is unwilling to change destructive behaviors. For example, a patient might say, "I am willing to start exercising because it will make me feel stronger and more relaxed while at the same time it will help my heart, but I am not willing to try to quit smoking. I just don't feel that I can do it right now; I'm under too much stress." It would be equally frustrating to develop a smoking cessation plan only to discover later that the patient had never had any intention of carrying out the plan. By assessing and accepting the patient's priorities, the physician obtains accurate information about a patient's willingness to follow a plan and creates a climate which makes it easier for the patient to return for assistance. The physician also offers her or his services to the patient as a resource person to whom the patient can return when s/he is ready to quit smoking.

When you see a patient with a resident, demonstrate this process to a resident, thereby stressing the importance of assessing patient priorities for behavior change. Also discuss the importance of finding out what changes a patient is ready to make before developing a treatment plan.

4. *Respond to patient interest in health promotion with specific suggestions for behavior change.*

Although a patient may be interested in changing a behavior it does not necessarily mean that the patient has any idea of how to go about doing so. Many patients have tried numerous times without success to quit smoking or to lose weight. It is important to help a patient to identify potential difficulties and to develop specific strategies to overcome them. This underscores the fact that the physician can work with the patient to solve future difficulties, and that setbacks do not need to result in defeat, but rather in a search for more useful strategies. When you see a patient who has expressed an interest in behavior change, you can ask a resident to observe and then discuss the encounter.

As an alternative, observe a resident during an encounter in which the resident works with a patient to develop strategies for behavior change. You can also discuss the encounter with the resident. The "Checklist for Patient Instructions" used in Module 3(page 122) lists important components of a short-term plan. It would be helpful to use this checklist in organizing a discussion about behavior change for health promotion.

5. *Identify family members and friends who can assist the patient in changing health related behaviors.*

It is important to take into consideration the impact of family and friends on a patient's attempts to change health related behavior. Family and friends can provide invaluable assistance and support to a patient by working with the patient to carry out a plan, and by encouraging the patient to continue with the plan. For example, a family member might agree to reward a patient with a small gift for each day the patient sticks to a predetermined diet, or a friend might take part in an exercise class with a patient.

Because a patient's behavior changes almost inevitably affect the daily routines and habits of friends and family members, support and assistance will not always be available to the patient. How will an overweight patient develop low calorie eating habits if the patient's family regularly eats high calorie meals? After asking a patient which friends and family members are likely to be helpful, a physician can assist a patient to incorporate specific roles for those people into the treatment plan. A physician can also help a patient to develop strategies for coping with difficulties which arise when family and friends are not willing to assist with the treatment plan.

When you see a patient with a resident, assess family support for behavior change, thereby stressing the importance of this factor. When an assessment reveals a problem, demonstrate how the problem might be solved. For example, a patient might reveal that he was having trouble sticking to his diet. Because his family was unwilling to give up sweets, the patient, seeing the candy left out in plain view, was regularly yielding to temptation. You could suggest that the patient ask the family to store the sweets in a less visible and less accessible place.

When a resident consults with you about a health promotion strategy outside of the examining room, ask the resident how supportive the patient's family and friends are. This tells the resident that you consider this to be an important factor to take into consideration.

6. *Request that patients keep a diary of behaviors.*

Most health promotion activities require changing behaviors which are long-standing, automatic, and almost unconsciously performed. A diary provides useful information for a patient, as well as a physician, about when, how often and under what circumstances a behavior such as smoking or eating occurs. This information is invaluable in the development of a treatment plan.

Suggest that a resident ask a patient to keep a diary of smoking or eating behaviors. You can go over the diary with the resident and help the resident to identify useful information and develop appropriate strategies. You can also suggest that a resident read Behavioral Self Control by Thoresen and Mahoney, or Slim Chance in a Fat World by Stuart and Davis. These books discuss the usefulness of behavioral diaries.

7. *Assist the patient in choosing a referral resource.*

A physician will not always have the time needed to help a patient carry out a behavior change. A physician can help a patient to choose one of the referral resources which are available in the community.

Because you are familiar with the characteristics of community resources, you can assist a resident in recommending appropriate resources to a patient. When you discuss health promotion activities with a resident, you can also describe resources for smoking cessation, weight loss, exercise programs and other health promotion activities.

APPENDIX 1

A PHYSICIAN'S EXPERIENCE WITH QUITTING*

Interviewer - You've been off cigarettes for four days now. How do you feel?

Physician - Awful.

Interviewer - Can you describe that in more detail?

Physician - Well, I lose my temper easily. I find it hard to concentrate. My teeth itch, my mouth waters. I feel dissatisfied. I'm not quite sure what to do with myself. I don't know how to face my days. Is that good enough for you? That's pretty miserable.

Interviewer - When do you miss smoking the most?

Physician - During a moment of crisis.

Interviewer - Have you tried anything else to make up for not smoking?

Physician - Chewing gum, eating lifesavers, eating more, drinking liquids, drinking alcohol.

Interviewer - Does that help you?

Physician - Yes. Certainly. It gets me past the crisis.

Interviewer - Have you ever stopped smoking before?

Physician - Many times. It's easy to stop smoking.

Interviewer - What were the things that you think made you fail before?

Physician - Crisis situations that I couldn't cope without a crutch.

Interviewer - Have you thought about any ways that you may get by those same sort of crises?

Physician - No. It worries me.

Interviewer - Can you think of other ways that you have of coping with those kind of crises?

Physician - No. If anything, I think I have a defect in that I can't cope with those crises without a crutch.

Interviewer - What sort of crisis specifically are you anticipating?

---

* This interview with a physician who had just stopped smoking is included to illustrate both the social and psychological effects of quitting.

Physician - A set back at work, an argument with my wife - that sort of thing. I'm an absolute masochist to go through the acute situation. I've done it before. Actually, I'm doing better now than some of the times I've done it before. I've quit smoking for as much as two years; once for four months, once for two years. Some for 24-48 hours, but this time it has been four or five days. And I just know - I know myself - everytime I quit, sooner or later I go back to it - not the first cigarette, but certainly by the eighth one, I'm back.

Interviewer - Well, you're certainly being very successful now. You've dealt with a lot of situations already that are stressful. You may not have dealt with them in the calmest way possible, but you've dealt with them without going back to smoking.

Physician - Yes, but you see there have been situations where I've not been smoking, where because I did not have my crutch, I have come close to losing my job, losing very many things that are important to me. That's frightening too. Yes, I cope with these situations, but so poorly that it's frightening.

Interviewer - Do you feel that people around you are supportive of your attempt to stop smoking?

Physician - My wife is. People at work generally think it's a good idea, but don't spend the day worrying about whether or not I smoke. I think there's a tremendous amount of social pressure now against smoking which is becoming quite annoying - holier than thou attitudes. But in terms of positive pressure, only my wife.

Interviewer - How do you think she would feel if you started smoking again?

Physician - I think she'd be disappointed, but understanding.

Interviewer - Let's change to another topic again. Tell me why you stopped smoking this time.

Physician - First of all, I'm going to be a father soon. I've decided maybe I'd like to live past forty because I'm going to have other responsibilities.

Interviewer - How old are you now?

Physician - Thirty-two. I'm fully aware of the fact that with the amount that I smoke my chances of getting an effect of smoking - coronary, pulmonary disease - are greater than my chances of not getting them. I understand that intellectually, but emotionally I still probably believe that it's not going to happen to me, even though I still see plenty of people that this happens to. So, one is that I have the intellectual understanding; two is, I just went on an airplane and they practically seated me in the toilet to let me smoke. They won't let me smoke on a bus.

Physician (cont.) - I went to a meeting, and I could only smoke in the back row. I smoke in front of children and they look at me like I'm some kind of dope fiend. I smoked in front of a friend recently who started coughing, turning blue and pointedly asked me to stop smoking. This is becoming a daily occurrence, and I like to be socially acceptable. It's like picking your nose in public now. And at work I have to go hide in the bathroom to smoke.

Interviewer - It seems to me that what you're saying is that, although you recognize intellectually the health factors, the things that really got you to stop smoking now were the social factors. The social pressures.

Physician - I don't think knowledge really helps. I think peer pressure, group pressure are the main things.

Interviewer - It's been five days now. Do you think you're going to make it this time?

Physician - I'm going to make it until my next huge crisis. So, if I make it past my first crisis, my second crisis might get me, and if the crisis is three weeks from now I'll make it to then. If it's three years from now, I'll make it to then. But sooner or later everyone comes to a point in life where he has a major reversal, a major disappointment, some major crisis or anxiety, where he frankly doesn't care. And then he goes back to crutches.

Interviewer - You really don't think that you will ever be a non-smoker?

Physician - No. I really think that I'm an addict and I'm quite frightened. I know drug addicts. They can quit. They can withdraw but they go back. The recividist rate is tremendous. I think it's the same thing with obese people and/or with smokers.

APPENDIX II

WEIGHT LOSS CHART REVIEW

INSTRUCTION PAMPHLET

IDENTIFICATION OF CHARTS FOR REVIEW

There are several methods of identifying appropriate charts to review. If a computerized problem list is kept for residency clinic patients, a computer search can be used to identify appropriate charts for review. Ask for a printout which lists:

1. Names of all patients whose problem lists include either obesity or overweight;
2. The name of each patient's resident physician;
3. The patient's identification number.

The daily appointment books maintained by the clinic receptionists can also be used to obtain patient names. Make a list of patients for whom weight check or obesity is listed as the reason for visit. This technique is sometimes unreliable. For example, hypertension might be recorded as the reason for a visit for a patient who is being treated for both hypertension and weight loss. As a supplement to the first two techniques of chart identification, ask nurses and residents to list names of patients the residents are treating for weight loss.

INSTRUCTIONS FOR USE OF CHART REVIEW PROTOCOL

CHART IDENTIFICATION SECTION

Date of the Chart Review

Record the date that the chart review is performed.

Responsible Resident

For the purpose of the chart review, the responsible resident is the resident who saw the patient about weight loss for the greatest number of visits.

Determining an Initial Visit Date

Once you have determined the patient's name, pull the patient's chart and find the visit at which obesity or overweight was first recorded as a problem. If the date of that visit is less than one year before the date of the chart review, begin the review at that visit. If the date of that visit is more than a year before the date of the chart review, begin the review at the visit which is about one year before the date of the review.

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Examples:

Chart Review Date	Obesity First Recorded	Initial Visit Date
1/1/80	6/11/79	6/11/79
1/1/80	6/11/78	visit closest to 1/1/79

Review every visit made by the patient beginning at the initial visit date and continuing through the date of the chart review. Every column on the Weight Loss Chart Review Protocol corresponds to one visit. The following are instructions for each row:

ENCOUNTER INFORMATION SECTION

Visit Date

Record the date of the visit being reviewed.

Main Purpose of Visit

Record the reason the patient has come to the clinic for this visit. This is usually contained in the appointment book or at the top of the chart.

M.D.

Record the name of the resident who is seeing the patient at this visit. This resident might not be the responsible resident.

The column marked "Expected Frequency of Performance" specifies the number of visits at which information pertaining to the chart review criteria should be recorded:

All	Ideally, this information should be recorded at least once.
1+	Ideally, this information should be recorded more than once.
1	Ideally, this information should be recorded once.

DATA SECTION

The symbols used to record data are 0 and +. When the progress notes in a chart indicate that a criterion was not met for a specific visit, record 0.

Visit date		2/28
Main purpose of visit		weigh-in
M.D.		Lesing
DATA:	Expected Frequency of Performance	
Weight	All	275
Final goal set	1	0

In this example, 0 signifies that there is no mention of a final goal for weight loss in the progress notes for a visit which took place on February 28. When the progress notes for a visit do contain a comment about a criterion, record +.

Visit date		2/28
Main purpose of visit		weigh-in
M.D.		Lesing
DATA:	Expected Frequency of Performance	
Weight	All	275
Final goal set	1	+

In this example, + indicates that there is a written comment about a final goal for weight loss in the progress notes of February 28.

Weight

Record the patient's weight for that visit. If the patient's weight has not been entered, record 0. This should be recorded at each visit.

Final Goal Set

Record whether or not the patient and the resident have identified a final goal for weight loss. This should be recorded at least once. If the progress notes indicate that a final goal has been set at this visit, record a +. If the progress notes do not indicate that a final goal has been set at this visit, record a 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient wishes to return to his marriage weight of 160	+
Told patient to lose weight	0
No mention of a final goal	0

Short-Term Goal Set

Record whether or not the patient and resident have set initial stage or week-to-week goals for weight loss. This should be recorded at each visit. If the progress notes indicate that a short-term goal has been set at this visit, record +. If the progress notes do not indicate that a short-term goal has been set at this visit, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Try to lose 1-2 lbs. per week	+
Patient advised to lose 30 lbs.	0
Eliminate bed time snacks	+
Short-term goal not mentioned	0

Past Attempts at Weight Loss Assessed

Record whether or not the resident has assessed strategies used by the patient in the past to lose weight. This should be recorded at least once. If the progress notes indicate that the resident has assessed strategies used by the patient in the past to lose weight, record +. If the progress notes do not indicate that the resident has assessed strategies used by the patient in the past to lose weight, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient previously lost 15 lbs. on 1400 calorie diet	+
Patient attempted Weight Watchers weight loss program 2 years ago, but was unsuccessful	+
Loss of 20 lbs. in past year	0
No comment about past attempts at weight loss	0

Family Support Assessed

Record whether or not the resident has determined the family is supportive of a patient's efforts to lose weight. This should be recorded at least once. If the progress notes indicate that the resident has assessed family support, record +. If the progress notes do not indicate that the resident has assessed family support, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Wife has stopped buying potato chips	+
Patient and family all overweight	0
Mother refused to buy foods for diet	+
Cookies offered frequently at home	+
No mention of family's support	0

Daily Eating Habits: Patient Diary

Record whether or not the patient has been asked to keep a diary of eating habits. This should be recorded at least once. If the progress notes indicate that the patient has been asked to keep a diet diary, record +. If the progress notes do not indicate that the patient has been asked to keep a diet diary, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient given diet diary	+
No mention of diet diary	0

Daily Eating Habits: 24 Hour Recall

Record whether or not the patient has been asked to list all foods eaten during the preceding twenty-four hours. This should be recorded at least once. If the progress notes indicate that the patient has been asked to describe what s/he has eaten during the last 24 hours, record +. If the progress notes do not indicate that the patient has been asked to describe what s/he has eaten during the last twenty-hour hours, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Pie and ice-cream as bedtime snack last night	+

(cont.)

Comment on Chart	Record on Chart Review Protocol
No mention in progress notes of what patient has eaten in preceding 24 hours	0
Patient eats three meals per day	0

Compliance Assessed

Record whether or not the resident has assessed the patient's compliance with the weight loss plan. This should be recorded at each visit. If the progress notes indicate that the resident has assessed compliance record +. If the progress notes do not indicate that the resident has assessed compliance, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient gained 3 lbs. since last visit	0
Patient has cut out bedtime snacks	+
Going to Weight-Watchers	+
Patient eating sweet rolls again - "likes to eat"	+

Patient Desire to Lose Weight Assessed

Record whether or not the resident has assessed the patient's attitude toward losing weight. This should be recorded more than once. If the progress notes indicate that the patients desire to lose weight was assessed, record +. If the progress notes indicate that no assessment of the patient's attitude toward losing weight was made at this visit, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient would like to lose 20 lbs. by summer	+
Patient not interested in weight loss counseling	+
Patient requested diet handout	0

INTERVENTION SECTION

Written Instructions

Record whether or not the resident has provided written instructions to the patient concerning weight loss. This should be recorded more than once. If the progress notes indicate that written instructions for weight loss were provided at this visit, record +. If the progress notes do not indicate that written instructions were given to the patient, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Try to lose 1-2 pounds per week	+
Maintain a 4 day diet diary - including 2 weekend days	+
Call weight loss clinic	+

Behavioral Plan Established

Record whether or not the patient and resident have developed a specific behavioral plan for weight loss. This should be recorded more than once. If the progress notes indicate that a behavioral plan was developed at this visit, record +. If the progress notes do not indicate that a behavioral plan was developed at this visit, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Eliminate snacking while watching TV	+
Walk at least 30 minutes each day	+
Lose some weight	0

Patient Given Information About Calories

Record whether or not the resident provided any information about the calorie content of food, daily calorie needs, or other information about calories. This should be recorded more than once. If the progress notes indicate that information about calories was provided at this visit, record +. If the progress notes do not indicate that information about calories was provided at this visit, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient given pamphlet on 1200 calorie diet	+

Patient Given Information About How To Lose Weight

Record whether or not the resident discussed methods of weight loss with the patient. This should be recorded more than once. If the progress notes indicate that the resident gave the patient information about how to lose weight, record +. If the progress notes do not indicate that the resident gave the patient information about how to lose weight, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Prolonged discussion of techniques of weight loss	+
Discussion of regular eating habits	0
Patient agreed to eat in kitchen only	0

Follow-Up Visit Set

Record whether or not the resident agreed upon a specific date for a return visit for weight loss with the patient. This should be recorded at each visit. If the progress notes indicate that the resident gave the patient a specific date for a return visit, record +. If the progress notes do not indicate that the resident gave the patient a specific date for a return visit, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
RTC for weight check in 2 weeks	+
Suggested patient return PRN	0

Mention of Weight at Visit

Record whether or not the resident made any comment about weight during a visit for a problem other than weight loss. This should be recorded at each visit. If the progress notes indicate that the resident made a comment about weight, record +. If the progress notes do not indicate that the resident made a comment about weight, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient looks heavier	0
Making good progress on diet	+

CHART REVIEW - WEIGHT LOSS

Patient ____________________

Chart No. __________________ Resident Responsible ______________

Age _____ Height _____ Date ______________________________

Visit date								
Main purpose of visit								
M.D.								
DATA:	Expected Frequency of Performance							
Weight	All							
Final goal set	1							
Small interim goals set	All							
Past attempts at weight loss assessed	1							
Family support assessed	1							
Daily eating habits assessed	1							
- By patient diary	1							
- By 24 hour recall	1							
Compliance assessed	All							
Patient desire to lose weight assessed	1+							
INTERVENTION: Written instructions (re: weight loss)	1+							
Behavioral plan established	1+							
Patient given information: - About calories	1+							
- About how to lose weight	1+							
Follow-up visit set (Not PRN)	All							
Mention of weight at visit	All							

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SAMPLE

CHART REVIEW - WEIGHT LOSS

Patient *Martha Quest*

Chart No. *432-5334*

Age *30* Height *5'8"*

Resident Responsible *Lesing*

Date *8/8/80*

Visit date		*5/31/80*	*6/3/80*	*7/8/80*	*7/20/80*			
Main purpose of visit		*Weight check*	*Cough*	*Weight check*	*Weight check*			
M.D.		*Holden*	*Lesing*	*Lesing*	*Lesing*			
DATA:	Expected Frequency of Performance							
Weight	All	*200*	*203*	*198*	*195*			
Final goal set	1	+	0	0	0			
Small interim goals set	All	0	0	0	0			
Past attempts at weight loss assessed	1	+	0	0	0			
Family support assessed	1	0	0	0	0			
Daily eating habits assessed	1	0	0	+	0			
- By patient diary	1	0	0	+	0			
- By 24 hour recall	1	0	0	0	0			
Compliance assessed	All	0	0	+	+			
Patient desire to lose weight assessed	1+	0	0	0	0			
INTERVENTION:								
Written instructions (re: weight loss)	1+	0	0	0	0			
Behavioral plan established	1+	0	0	0	0			
Patient given information:								
- About calories	1+	0	0	0	0			
- About how to lose weight	1+	0	0	0	0			
Follow-up visit set (Not PRN)	All	+	0	+	0			
Mention of weight at visit	All	+	0	+	+			

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MODULE 5

LONG-TERM STRATEGIES IN PATIENT EDUCATION: THE SPECIAL REQUIREMENTS FOR CHRONIC DISEASE

MODULE 5

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INTRODUCTION

The patient with a chronic illness presents a complex educational challenge to the primary care physician. To meet this challenge, the physician must apply all of the patient education skills of the earlier modules. Basic communication skills are necessary to explain complicated diagnostic tests and treatment plans. An understanding of the patient's perception of a chronic illness, its potential consequences and the impact of treatment on everyday life is crucial in developing educational and treatment plans that address the individual patient's needs. The treatment plan must include all of the components of a good educational plan, including adaptation to individual needs, as well as clearly specified instructions and outcomes.

Because much of the process, content and strategies required for chronic illness education are extensions of the content of earlier modules, an introductory seminar is not presented in this module. Instead, the special dimensions of education for a chronic illness are illustrated in each activity. A simulation activity provides the resident with experience in reaching agreement on a chronic illness diagnosis and prognosis from both the physician's and the patient's point of view. A review of charts for each resident's hypertensive patients provides individual and group data on current levels of charted patient education activities and identifies strategies for creating and documenting long-term educational plans. Finally, each resident is asked to select one patient with a chronic disease to be interviewed by the patient education staff. This in-depth interview explores the patient's understanding of her or his condition and its treatment and gathers information about problems the patient has encountered in coping with treatment. A summary of the interview serves as the basis of a discussion between the resident and the interviewer on current education and treatment strategies and on developing a long term patient education plan.

OBJECTIVES FOR MODULE 5

Residents will demonstrate an ability to:

1. Establish agreement with the patient about the diagnosis;
2. Present a manageable amount of information to the patient;
3. Assess and share with the patient physiological changes in specific terms; e.g., blood pressure and weight;
4. Provide the patient with an opportunity to talk about general attitudes, fears and depression concerning condition;
5. Engage the patient in an active role of selecting educational methods and carrying out treatment plan;
6. Assess influence of relevant environmental situations; e.g., employment status, work conditions and work schedule, on the patient's ability to adapt to a long-term condition;
7. Assess patient adherence to previous treatment plans.

DISCUSSION OF MODULE 5 OBJECTIVES

1. *Residents will establish agreement with the patient about the diagnosis.*

Patients are often confused or unsure about diagnoses (Svarstad and Lipton, 1978). Establishing explicit agreement with the patient on the diagnosis makes a shared understanding of the condition and its treatment more likely. The initial diagnosis of a chronic or long-term condition can produce anxiety in both the physician and the patient. When the physician takes the time to establish explicit agreement on the diagnosis, s/he allows the patient to respond to the diagnosis and emphasizes the importance of the treatment plan.

2. *Residents will present a manageable amount of information to the patient.*

A patient is able to absorb only a limited amount of information at one time. Ley (1977) and Podell (1975) have stressed the importance of presenting a manageable amount of information to the patient. Chronic conditions usually require several visits to cover all of the important information about the condition, its etiology and course of treatment. If the resident takes extra time to provide all of this information at a single visit, the patient can become frustrated because it is impossible to remember all of it, and the physician will likely need to repeat much of it at subsequent visits.

3. *Residents will assess and share with the patient physiological changes in specific terms; e.g., blood pressure and weight.*

Patients have a basic right to medical information in specific and understandable terms. Vague reassurance, such as, "Your blood pressure is okay," does not specifically tell what the patient's relation is to the treatment goal. A patient needs specific feedback in order to assess how her or his changes in behavior are making measurable changes in her or his body. For example, providing the hypertensive patient with a blood pressure reading on each visit demonstrates the efficacy of treatment and helps the patient understand the relationship between what s/he has done, such as taking medicine or exercising and the treatment outcome (Svarstad, 1981).

4. *Residents will provide the patient with an opportunity to talk about general attitudes, fears and depression concerning condition.*

A patient can react to the diagnosis of a chronic condition in many ways. Medical knowledge as well as past, personal and family history affect the way the patient will think about the diagnosis and treatment. A patient's fears and attitudes about potential restrictions in activity, disabling complications or painful treatments can be either accurate or inaccurate and, therefore, need to be discussed and clarified. A patient's acceptance of a chronic condition requires time. Accurate information about the condition and the specifics of its treatment will help the patient to recognize and deal with the fear and the depression that commonly accompany new diagnoses of chronic illness (Nerenz, 1979).

5. *Residents will engage the patient in an active role of selecting educational methods and carrying out treatment plan.*

In conditions that require long-term treatment plans, the patient is the one who must carry out the required actions. The patient is in the best position to assist the physician in tailoring the plan. Such active participation has been identified as an important correlate of good adherence and blood pressure outcomes for hypertensives (Shulman, 1979). Many patients will alter treatment plans on their own (Meyer, 1980).

Rather than ignore this problem, physicians can present appropriate alternatives and allow the patient to select one. This selection process involves an overt commitment by the patient and will make follow-through more probable (Levy et al., 1980).

6. *Residents will assess influence of relevant environmental situations; e.g., employment status, work conditions and work schedule, on the patient's ability to adapt to a long-term condition.*

A medical treatment plan, especially a plan designed to treat a long-term condition, is more easily followed if it is incorporated into the individual patient's daily schedule (Fink, 1976; Podell, 1976). Environmental influences, such as a "swing shift" worker's erratic schedule, can make following a complex medication plan difficult. Plans can usually be altered or simplified to avoid these difficulties.

7. *Residents will assess patient adherence to previous treatment plans.*

Adherence to treatment plans has been the focus of intensive behavioral research (Sackett and Haynes, 1976) and has been identified as a particular problem in long-term therapies such as high blood pressure (Leventhal et al., 1980). Assessment of adherence by the physician through careful questioning can uncover side effects, misunderstandings about regimen, and simple problems in following the plan. These problems can then be discussed and potential solutions tried. Assessing adherence has the added benefit of stressing the importance that the physician places on the treatment plan and can itself increase adherence (Svarstad, 1974).

SEMINAR FOR MODULE 5

A SIMULATION: THE EMOTIONAL IMPACT OF A CHRONIC ILLNESS DIAGNOSIS*

This simulation exercise is designed to help primary care residents to experience vicariously the emotional impact of a diagnosis of a debilitating chronic illness. During the first part of the simulation exercise, residents are divided into groups of three and asked to assume the role of a patient, a significant other, or a physician. In the course of several rounds of interactions, each group discusses a diagnosis and a prognosis of a patient's steadily worsening condition. At the end of the exercise, residents are encouraged to discuss their reactions and perceptions.

PREPARATION OF THE SEMINAR LEADER

A careful reading of the seminar materials is necessary in order to direct the residents through the different steps of the simulation exercise. A familiarity with the difficulties involved in adaptation to chronic illness is required in order to help residents to discuss the simulation and to gain useful insights. Strauss' book, Chronic Illness and the Quality of Life (1975), presents a thorough discussion of the problems engendered by a chronic illness. Other Module 5 materials also provide excellent background readings for this seminar.

There are five script packages for this simulation exercise. Each package consists of:

1. A patient script;
2. A significant other script;
3. Diagnostic information;
4. A summary of communication strategies for patients;
5. A summary of communication strategies for physicians.

Prepare separate role sheets for patients and significant others as well as separate diagnostic information sheets and strategy summary sheets.

This simulation can be carried out with a minimum of nine individuals. Three to five groups of three persons each. Less than three groups will not allow sufficient variety to promote adequate discussion and insight. If there are not enough residents, faculty and staff can participate in the exercise. As many as five groups of three individuals, a total of fifteen people, can participate. A room should be used which is large enough to allow each group of three persons to conduct separate conversations without distracting one another.

*G. Thomas Pfaehler, M.D., of the University of Wisconsin Department of Family Medicine and Practice adapted the Terminex Game for this seminar. The Terminex Game was initially designed by Patricia Murphy, R.N., M.S., of Rutgers University College of Nursing, Newark, New Jersey.

A minimum of 90 minutes is required to perform the simulation exercise. If less than 90 minutes is scheduled there will not be sufficient time for discussion, which is an essential part of the seminar.

PREPARATION OF THE RESIDENTS

Inform the residents that all participants must be present before the simulation exercise can begin. Request that the residents make every effort to arrive promptly at the seminar.

SEMINAR OUTLINE

I. Introduction: Rationale For A Simulation Exercise

- A. Simulations are designed to provide essential qualities of real situations, but do not mimic reality completely.
- B. This simulation is designed to recreate certain characteristics of the interchange between a patient, a significant other and a physician about a diagnosis of chronic illness. Participants will be encouraged to examine their responses and reactions to this simulated situation because:
    1. It is important for physicians to be aware of the impact they have on patients.
    2. It is also important for physicians to have an understanding of how they react with patients during encounters that involve such emotionally-laden topics as chronic illness.
- C. This simulation provides an opportunity for physicians to try several methods of informing a patient of a chronic illness diagnosis. During the discussion period, participants will be asked to discuss how they felt about each method. Participants can use this basic information to make decisions about changing or maintaining the way in which they approach patients and their families.
- D. Residents often have the impression that they are supposed to know the "right way" to discuss a diagnosis with patients. This "right way" is a method of communicating a diagnosis without upsetting a patient. This is an unrealistic expectation.

II. General Instructions for Simulation Exercise

- A. Assign participants to groups of three individuals.
- B. Divide the roles of patient, significant other and physician among the three members of each group.
- C. Distribute patient and significant other scripts to the appropriate members of each group. Give each group a different script package.

N.B. Do not distribute diagnostic information sheets, or strategy summary sheets at this time.

D. Explain that the exercise will consist of several rounds of interactions and that participants will keep their roles for the duration of the exercise.

III. Specific Instructions for Each Role.

A. Give the participants who have the role of either patient or significant other the following information:

1. Use the script to determine how you play your role.

2. You may:

   a. Ask questions;
   b. Respond to questions;
   c. Make comments or statements.

3. The more you get into your role, the more you will get out of the experience.

4. You will remain in this role and group for the entire exercise.

B. Give the participants who have the role of physician the following information:

1. Play the role of a general physician who is meeting a patient for the first time in the hospital. You may account for that any way you wish. For example, as:

   a. A physician covering for a partner;
   b. A physician accepting a previously unassigned patient.

2. Each patient has a set of symptoms which s/he will divulge to you as s/he sees fit during the course of your interchange.

3. During the next five minutes, get acquainted with your patients. Determine how you will deliver care to this patient and her or his significant other. They will reveal, in response to questioning, what their situation is and what is happening in their lives. Some of the questions you may want to find answers for are:

   a. What kind of person is this patient?
   b. How open do I have to be?
   c. What does this patient expect of a physician?
   d. What does this patient need from a physician?

IV. Round 1.

A. Send each group to a separate location in the room. Explain that the first part of the exercise will last for five minutes.

B. When the five minutes have elapsed, request that all participants who are playing the role of physician join you outside of the room.

C. Give each physician the diagnostic information that pertains to her or his patient. Emphasize that neither the exact detail of the laboratory studies, nor the number, nor the qualitative findings are as important as the conclusion listed at the end of the sheet.

D. At this point, the physicians are likely to ask many questions. Those who are not in real life physicians may claim ignorance of all laboratory information. Deal with this by reiterating that the important issue is the conclusion on the sheet, which, in all cases is a diagnosis of a chronic condition characterized by unpredictable worsening and an exacerbating course.

E. Once the physicians have briefly scanned this sheet, give them the additional information that each of their patients will suffer an exacerbation of her or his condition within the next twelve months.

F. Give each physician a copy of the "Summary of Strategies for Physicians." Ask each physician to decide which strategy s/he will use to convey the diagnostic information to her or his patient.

G. Give the physicians two or three minutes to plan how they will approach their patients. During this time, return to the other room and distribute a copy of the "Summary of Strategies for Patients" to each patient and each significant other. Ask each of these people to select a strategy that s/he will use to interact with the physician.

H. Ask the physicians to return to their groups. Tell them that they have seven minutes to discuss their findings with their patients and significant others. Let them know that they are free to expand their roles by making up answers as they see fit.

I. After the seven minutes have elapsed, collect the scripts from the patients and the significant others. Ask the physicians to return the diagnostic information sheets and to move to a new group.

J. If the participants express a desire to begin discussion of their experiences, ask that they wait until the end of the exercise to do so.

V. Round 2.

A. Tell the patients and the significant others to retain the symptoms that were described in their scripts, but to assume their own personal identities, such as age, name and personality.

B. Tell the physicians that they are now encountering a new patient and a new significant other, and that they will have five minutes to get to know these people.

C. When the five minutes have elapsed, request that the physicians join you outside of the room.

D. Give each physician the diagnostic information that pertains to her or his patient. Again, emphasize that the important information is the conclusion listed at the end of this sheet.

E. Give the physicians the additional information that each of their patients will suffer an exacerbation of her or his condition within the next nine months. (The period of time decreases by three months with each round.)

F. Ask each physician to examine the "Summary of Strategies for Physicians," and to decide which strategy s/he will use to convey the diagnostic information to her or his patient. Urge the physicians to select a different strategy for each round.

G. Give the physicians two or three minutes to plan how to approach their patients.

H. Return to the room and ask the patients and significant others to select a strategy with the physician. Urge them to try a new strategy.

I. Ask the physicians to join their patients, and tell them that they again have seven minutes to discuss their findings.

J. After the seven minutes have elapsed, ask the physicians to move to a new group.

VI. Remaining Rounds.

A. Go through at least three rounds.

B. The instructions for Round 2 apply to each subsequent round.

C. Remember to

1. Shorten the time period within which the patient will suffer an exacerbation of her or his condition by three months for each successive round. Thus, in Round 1, the time period is twelve months; in Round 2, the time period is nine months; in Round 3, the time period is six months; in Round 4, the time period is three months, and in Round 5, the time period is one month or less.

2. Encourage the patients, significant others, and physicians to

experiment with alternative strategies for handling the diagnostic information.

3. Ask the physicians to move to a new group for each round.

VII. Discussion

A. After the final round, reassemble the group. Use the remaining time to discuss feelings aroused by the simulation. Participants may complain about the inaccuracies or inadequacies of the clinical pathological data. Acknowledge that indeed the simulation is difficult, but that the major goal is to examine their feelings and responses in a simulated situation involving a chronic illness.

B. The simulation is designed to provide an experience through which residents will learn about their personal styles and their reactions to chronic illness. This is its main strength. Your major task in the discussion section is to direct the group's attention to the feelings and to the way in which they put these feelings into words. Elicit the reactions of participants to the experience that they have just been through. When reactions clearly identifiable as feelings about chronic illness are voiced, paraphrase or highlight these reactions.

C. Questions to ask those who played the role of physician:

1. How did you feel about communicating the diagnostic information to your patient? What was difficult?

   Responses might include:

   a. Knowing how to approach the patient.
   b. Using a communication strategy, such as denial, which is not the participant's normal style.
   c. Conveying the seriousness of the condition.
   d. Describing the uncertainties of the patient's illness.
   e. Explaining concepts in a simple and understandable manner.
   f. Telling the patient that an exacerbation of her or his condition was imminent.

2. In what types of situations or with what kinds of patients would you be most likely to use:

   a. Bluntness;
   b. Denial;
   c. Avoidance;
   d. Mystification;
   e. Optimism.

D. Questions to ask participants who played the role of patient or the role of significant other:

1. How did you feel when the physician talked with you about the diagnosis of your condition?

   Responses might include:

   a. Disbelief;
   b. Shock;
   c. Overwhelmed;
   d. Unable to hear what the physician was saying;
   e. Unable to understand terms, concepts;
   f. Anger.

2. What was your understanding of what the diagnosis was and what it would mean for you?

3. What did you think about?

4. How actively did you participate in the interchange with the physician? How much control did you have over what was discussed?

E. Questions to ask all participants.

1. Which communication strategies did you use?

2. Which communication strategies did the other members of your group use?

3. Which communication strategies did you feel most or least comfortable with? Why?

4. What happened to the discussion when a member of the group chose to

   a. Be blunt;
   b. Deny;
   c. Avoid;
   d. Be optimistic.

5. What happened when the patient and the significant other took on their own personalities in Round 2?

6. What differences did you notice between what happened in Round 1 and Round 2?

7. With each round, the time period within which the patient would experience a crisis was shortened. What impact did that have on the discussions? On the interactions between the group members? On you?

8. Will your experiences or discussion today lead you to change the manner in which you inform a patient of a chronic illness diagnosis? How?

9. Who controlled your discussions? Who decided which communication strategy would be used? How?

F. Summarize discussion.

SCRIPT PACKAGE 1

MARY SMITH

Patient Script

You are MARY SMITH, age 36, married, with 5 children ages 2 through 14, and a homemaker. Last year you had an episode of double vision which passed rapidly but frightened you and your physician. You are now in the hospital because an episode of numbness and weakness in your left hand has caused your physician to request a neurological evaluation. Your initial reaction was that you "injured a nerve," and you deny the fact that all your symptoms may be indicative of a neurological illness of a progressive type like that of your mother and older sister.

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Significant Other Script

You are MARY SMITH'S husband, JACK. One year ago your wife had an episode of double vision. At that time, you were frightened because of the hedging and concern about the diagnosis exhibited by your physician, and you began drinking intermittently. You have 5 children ages 2 to 14. The hospitalization causes you much anxiety, and again you are drinking heavily to avoid thinking about your wife's illness. When you visit Mary you appear disinterested and preoccupied.

*****

Diagnostic Information

NAME: MARY SMITH HISTORY NUMBER: 63720-1

TEST: Cerebro spinal fluid examination

RESULTS: Cultures are negative and no abnormality is noted in the glucose level or cell counts. No cells were seen. Cerebro spinal fluid protein electrophyresis is consistent with the diagnosis of demylinating disorder.

IMPRESSION: Demylinating process, probably multiple sclerosis.

PROGNOSIS: Guarded.

SCRIPT PACKAGE 2

JANE SMART

Patient Script

You are JANE SMART, a 25-year-old graduate student, engaged to be married immediately after graduation. You accidently ran into a bicycle rack when you were riding home and suddenly suffered a precipitous decrease in vision. This episode occurred last week and resulted in your being referred to the local hospital emergency room. You have been a known diabetic since age 12, on insulin, and in good control since age 13. You were admitted for further work-up and evaluation.

*****

Significant Other Script

You are JANE SMART'S boyfriend, JOEL. You and Jane plan to be married next month. Both of you are graduating from college with master's degrees this June. Neither you nor Jane have any living parents, and all you have is each other. After many years of struggling, life is just starting to be good for both of you, and you both look forward to many years of happiness.

*****

Diagnostic Information

NAME: JANE SMART HISTORY NUMBER: 63730-2

TEST: Ophthalmology consult, emergency

RESULTS: Multiple retinal hemorrhages of a fresh nature. There is no arterial pulsation in the retinal artery on the right. There are vascular changes consistent with severe small vessel disease.

IMPRESSION: Severe diabetic retinopathy.

PROGNOSIS: Guarded.

SCRIPT PACKAGE 3

ALEXIA ANTHONY

Patient Script

You are ALEXIA ANTHONY, a 40-year-old single physician. Although the hospital personnel have not yet said so, you are suspicious that your headaches point to an inoperable brain tumor, or something equally serious. You have been neglecting your health since college in spite of a strong family history of cardiovascular disease. You are extremely angry that this illness could happen to you at a time when you have succeeded in becoming a prominent professional in the medical field. You are also furious with the hospital staff and your friends for their obvious denial of your probable serious illness.

*****

Significant Other Script

You are ALEXIA ANTHONY'S best friend, DANA, with whom you share an apartment near the hospital where you both work. You are also a physician. You do not believe that Alexia could change her life to accommodate a serious, chronic illness. You continually stay with her and attempt to cheer her up. You seriously believe that she could not continue to live if she had to give up her pace and accomplishment as a very active and energetic physician.

*****

Diagnostic Information

NAME: ALEXIA ANTHONY HISTORY NUMBER: 53720-3

TEST: I.V.P., V.M.A., 5 H.I.A.A.

RESULTS: All chemical tests within normal limits.

IMPRESSION: No indication of endocrinological or renal cause for hypertension. Results are consistent with essential and currently malignant hypertension.

PROGNOSIS: Fair, with rigid control.

SCRIPT PACKAGE 4

DENISE ANDERSON

Patient Script

You are DENISE ANDERSON, a 19-year-old student who is angry because you have to stay in the hospital. You have a tenderness and a lot of pain in the abdomen. Your mother won't leave you alone; she just sits and worries all the time. You've never been really sick before. You are fed up with having blood tests and x-rays and so forth. While you have been bothered with some discomfort and anxiety around menstrual periods for approximately 2 years, you have never experienced anything as excruciating as that pain currently associated with your on-going menstrual period.

*****

Significant Other Script

You are DENISE ANDERSON'S mother, MAMIE. Your daughter is in the hospital and your doctor has given you reason to be concerned. They have taken many tests and your doctor has said that some of them look suspicious. Deniseis your only child and you have been a widow since she was 3 years old. She is all you have.

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Diagnostic Information

NAME: DENISE ANDERSON HISTORY NUMBER: 63720-5

TEST: Culdoscopy

RESULTS: Examination by culdoscopy reveals evidence of multiple endometrial implants.

IMPRESSION: Endometriosis.

PROGNOSIS: Guarded with probable recurrent episodes of pain of increasing intensity throughout reproductive life.

SCRIPT PACKAGE 5

JOSEPH PETRONI

Patient Script

You are JOSEPH PETRONI, a 50-year-old Italian immigrant, married with 7 children (ages 8 to 21 years), and a manual laborer. You are seriously concerned about your physical condition. Because of pain in your chest and some difficulty breathing, it has become increasingly difficult for you to work. You have known for a long time that you have high blood pressure. The doctor has prescribed medications which you do not take because you "do not like pills." Over the past 4 months you have missed work frequently because of your sickness. You were admitted to the hospital with presenting symptoms of severe breathing difficulty and excruciating chest pain. Your immediate diagnosis was a heart attack. However, you expect you have an illness which will prevent you from ever returning to work. You fear that you will not be able to continue as head of your family. Because of your concern, you want to know exactly what your real diagnosis is. You believe that the doctors have not been telling you the truth about your illness.

*****

Significant Other Script

You are JOSEPH PETRONI'S wife, GINA. You have 7 children ages 8 through 21. You have never worked outside your home in your life. You are very concerned about your husband's health and worried about the medical bills. You've been told by his doctor that he has high blood pressure and that he should be taking medications. You have, however, had no luck in convincing him to take his medications regularly and you have been increasingly concerned over his symptoms and his health. You refuse to believe that there could be anything seriously wrong with your husband. You think that the doctors have made a mistake by admitting him to the hospital. You want to stay in the hospital all the time to be sure that they don't do anything to hurt Joe.

*****

Diagnostic Information

HISTORY NUMBER: 63720-4

NAME: JOSEPH PETRONI

TEST: E.C.G. and chest x-ray

RESULTS: Chest x-ray reveals marked enlargement of the cardiac silhouette consistent with the diagnosis of ventricular hypertrophy because of high blood pressure. Electrocardiogram confirms the diagnosis of acute myocardial infarction.

IMPRESSION: Severe hypertensive cardiovascular disease with myocardial infarction.

PROGNOSIS: Very poor without compliance in treatment in both developing congestive heart failure and hypertension.

SUMMARY OF STRATEGIES FOR PATIENTS

You have an idea that your illness is serious, but you are not really sure just how serious. The consulting physician has completed the tests and examined the results. When the physician talks with you, which of the following would you prefer? Select one for the observer to record on your score sheet.

Strategies

1. Bluntness: You would like the actual diagnosis and prognosis immediately and straightforwardly.
2. Denial: You would rather the physician hid the truth from you. You really don't want to know.
3. Avoidance: You would like the physician to avoid the whole question for the moment.
4. Optimism: You would like the physician to reinforce your hope and optimism in talking with you.

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SUMMARY OF STRATEGIES FOR PHYSICIANS

You have just received your patient's diagnosis and prognosis. Below are five strategies you may use for handling the diagnosis and prognosis. Choose one strategy and communicate this choice to your observer before beginning the next round.

Strategies

1. Bluntness: You believe this patient should be told the actual diagnosis and prognosis as soon as possible.
2. Denial: You do not believe it to the patient's benefit to be told the diagnosis and/or prognosis.
3. Avoidance: You believe it is best not to discuss the patient's diagnosis or prognosis at this time.
4. Mystification: You believe it best to mask the severity of the patient's diagnosis and prognosis by using medical terms.
5. Optimism: You believe it is best to reinforce hope and optimism in discussing the situation.

IN-DEPTH INTERVIEW AND FEEDBACK ACTIVITY FOR MODULE 5

Often the interchange between a physician and a patient follows an informal script, whereby the same topics are discussed at each visit. As a result, many important issues are not addressed. This may cause a physician to be unaware of the problems a patient faces in adapting to the limitations imposed by a chronic illness. Routine inquiries about issues of understanding, compliance, adaptation, family support and cost of treatment enable a physician to work with a patient to develop strategies for coping with chronic illness.

The purpose of this activity is twofold:

1. To demonstrate to residents the value of assessing a patient's understanding of and adaptation to chronic illness;

2. To familiarize residents with the process of developing a long-term educational plan for a patient with a chronic illness.

Residents are asked to identify patients with chronic illness. One patient of each resident is interviewed about her or his understanding of and adaptation to chronic illness. Residents are asked to use the information gathered in these interviews to assess a patient's needs and to develop a long-term educational plan that addresses those needs.

OBJECTIVES

The resident will develop a long-term educational plan for a patient with a chronic illness. The plan will take into consideration the following issues:

1. Patient's beliefs about the illness and the treatment plan;

2. Patient's adaptation to the demands and limitations of the illness and the treatment plan;

3. Financial impact of the illness and treatment plan;

4. Response of the patient's family to the patient's illness and treatment plan.

PREPARATION OF THE INTERVIEWER

In order to conduct this activity, it is necessary to be aware of the issues related to the adaptation to chronic illness and the potential role of the physician in assisting the patient. Such issues include the psychological impact of a chronic illness diagnosis, the changes in family and work patterns necessitated by long-term illness and treatment, the overwhelming amount of information about the condition and its effective treatment that must be provided to the patient, and the complex behavioral issues involved in changing and sustaining charges in lifelong habits.

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An excellent introduction to this area is Aiken's chapter, "Chronic Illness and Responsive Ambulatory Care" (1976). Strauss' book, Chronic Illness and the Quality of Life (1975), also presents a thorough discussion of the problems of living with chronic disease, and provides illustrations of the implications of specific chronic illnesses including ulcerative colitis, rheumatoid arthritis and emphysema. Once again, Lear's book, Heartsounds presents a detailed picture of one patient's struggle to adapt to a chronic condition (see Module 2). Bruhn (1977), Mullen (1978), and Owen (1975) have also written articles about these issues.

Explain that the purpose of the interview activity is to help residents to ascertain a patient's adaptation to chronic illness and to develop educational plans that fit a patient's needs. Ask each resident to select one or two patients who;

1. Are currently outpatients;
2. Have been seen at least three times by the resident;
3. Identify the resident as personal physician;
4. Have had a diagnosed chronic illness for at least six months. Generally, this is the amount of time required for a patient to recover from the initial shock of a diagnosis and begin to cope with adaptational issues.

Ask the residents to suggest topics or questions for inclusion in an interview of a particular patient. Topics residents may identify are adherence to treatment plan, understanding of illness, or satisfaction with care.

It is easiest to interview patients immediately after a clinic visit. Give the clinic receptionists a list of the patients whom you wish to interview, and ask them to notify you when each patient schedules an appointment. Schedule an interview with one patient for each resident.

INSTRUCTIONS FOR THE INTERVIEW

Interviews, which last about twenty minutes, are most easily scheduled to follow a clinic visit. A quiet private room is necessary to create a relaxed atmosphere for an interview, and to insure confidentiality. If the patient extends permission to do so, make a tape recording of the interview.

Before starting the interview, obtain the informed consent of the patient. Explain to the patient the following:

1. The purpose of the interview is to find out how the patient is adapting to her or his illness and to identify any ways in which the physician can assist the patient.
2. The patient has the right to refuse permission to:
    a. Be interviewed.
    b. Have an interview taped.

c. Continue an interview.
d. Answer any question.

Such refusal will not affect the patient's ability to receive care at the clinic.

3. A tape recording and anything said during the interview will be shared with the resident and the resident's supervisors, but will otherwise remain confidential.

4. The interviewer cannot answer questions about the patient's condition or treatment plan. All questions will be referred to the patient's physician.

Questions that can be used as a guide are listed on the following page. The categories are: condition, medications, diet, exercise, general, and questions suggested by resident. Strict adherence to the wording or the order of the questions should be avoided, as it would result in a stilted and unproductive interview. Rather, have a conversation with the patient, asking open-ended questions about the issues addressed to the questionnaire.

When you do not tape an interview, take notes of a patient's responses. Try to write down the exact wording of a patient's statements that reflect her or his understanding of the condition or treatment plan.

SUMMARY OF THE INTERVIEW

As soon as possible, write a summary of the interview. Because the patient's actual words convey subtleties of meaning that would be lost through paraphrase, include direct quotes from the patient.

Questions to Address In the Summary

1. *What is the patient's understanding of her or his condition?*

   Misunderstandings about the diagnosis or the physiology of a condition can have many negative consequences. A patient who mistakenly believes an illness to be acute rather than chronic, is likely to drop out of treatment. A patient who does not understand the beneficial impact of a treatment plan on a condition may not adhere to the treatment plan. A patient who is unaware of the common signs and symptoms of a condition may become unnecessarily alarmed. The patient may attribute the cause of a symptom to the treatment plan, and consequently abandon treatment.

2. *What physiological measures does the patient believe the resident is using to assess progress?*

   It is important for a patient to understand the specific physiological measures which are used to monitor her or his condition. This knowledge enables a patient to become active in monitoring her or his own care. For example, when given information about acceptable ranges of blood pressure and taught the proper use of a sphygomamanometer, a

IN-DEPTH INTERVIEW:

SAMPLE QUESTIONS

CONDITION

1. Tell me what your understanding of your condition is?
2. How does your condition affect your body?
3. What do you think caused it?
4. What did the doctor say was the cause?
5. How long do you think it will last?
6. How long did the doctor say it will last?

MEDICATIONS

7. What kind of medicine did the doctor give you? (or ask you to take)
8. When do you take it?
9. How do you remember to take it?
10. What do you do if you forget to take it?
11. Is there anything that makes it hard to take it? (schedule, cost, side effects, etc.)
12. Sometimes medicine has unpleasant effects - has that been true for you? What do you do when that happens?
13. What do your family and friends think about your taking medication?
14. How does the medicine help your condition?
15. Are there times when it doesn't work? What do you do then?

DIET

16. Are there any foods the doctor wants you to avoid (or add to your diet?)
17. How successful have you been at making those changes?
18. What helped (made it hard) for you to follow your diet?
19. How has your family responded to your diet?
20. What do you do about (eating at work, vacations, holidays, parties, going out to eat) or, what effect have vacations, holidays, etc. had?
21. Why is a special diet important for your care?

EXERCISE

22. What has the doctor told you about getting exercise?
23. Why is it important for your care?
24. What exercise do you get? How successful have you been at exercise?
25. How do you set aside time to exercise?
26. What's made it hard for (or helped) you to exercise?

GENERAL

27. What has the doctor told you s/he uses to figure out if you're getting better or worse?
28. How do you know if you are getting better or worse?
29. What do you expect will happen if you see your doctor and do what s/he recommends?
30. Which of the things that your doctor recommended do you think are the most important?
31. Which do you think are the easiest to do?
32. Which do you think are the hardest?

IMPACT ON LIFE

33. How has your illness affected your daily routine? (everyday activities?)
34. How have your family and friends reacted to your illness?
35. How much do the things you need to care for your illness cost you each month? (include cost for medications, diet, any special equipment)
36. Does your insurance help pay for it?

QUESTIONS SUGGESTED BY RESIDENT:

hypertensive patient can chart home blood pressure readings. The patient can be instructed to call the clinic when her or his blood pressure exceeds a certain limit.

Teaching a hypertensive patient to self-monitor will eventually save time for the physician as s/he will no longer need to schedule clinic visits with the patient for the sole purpose of monitoring blood pressure. Any patient who is actively involved in monitoring her or his own progress is in a position to evaluate the necessity and effectiveness of a treatment plan in an informed manner. A patient who is not given accurate methods of assessing the progression of a condition is likely to develop her or his own idiosyncratic methods, which may be seriously misleading.

3. *What problems has the patient had with the treatment plan (medications, diet, exercise)?*

Patients who have long-term conditions are usually faced with the prospect of permanently and radically altering daily routines and lifelong habits. Considerable effort is often required to adhere to a medication regimen; many medications produce undesirable effects. Exercise and eating habits are notoriously difficult to change. A patient who is not assisted in overcoming any problems may alter or discontinue treatment.

4. *How has the patient's condition affected her or his life (daily routine, relationship with family and friends, burden of cost)?*

A long-term condition frequently causes serious physical and emotional distress. The direct physical consequences of a condition, pain and the effects of medications often result in a severe curtailment of a patient's physical abilities. A patient's daily routines can be affected drastically, either as a result of the physical limitations imposed by a condition or by the behaviors and expense required by a treatment plan. The cost of medical care can pose a threat to a patient's financial security. All of these factors can have a strong impact on a patient's relationship with family, friends, co-workers and employers.

If these problems are not identified, a patient may either ignore some or all of the components of a treatment plan, or even drop out of treatment. Even when a patient does attempt to adhere to treatment, the many stresses caused by the patient's condition often have negative effects on her or his physical and emotional well-being. A physician can assist a patient in problem solving and developing coping strategies that address the patients needs. As an alternative, the physician can assess a patient's adaptational needs, and refer the patient to a nurse or another appropriate referral resource.

DISCUSSION OF THE INTERVIEW

Present your summary of the interview to the resident. Using the following questions, work with the resident to formulate a long-term patient education plan to address the needs of the patient. N.B. If a tape recording of the interview is available, you might choose to listen to the tape with the resident and ask the resident to summarize the interview. The amount of time required to do so, 30-45 minutes, may be prohibitive.

1. Are you and the patient in agreement about the diagnosis?
2. Does the patient understand how the treatment plan affects her or his condition?
3. Does the patient have a sufficient understanding of her or his condition to explain any new symptoms, sensations or treatment options that might occur in the future?
4. What new or different information do you want to convey to the patient about her or his condition?
5. How will you present this information so that the patient will be able to understand it?
6. Does the patient have an accurate perception of the physiologic measures you use to assess her or his condition?
7. Does the patient use a realistic method of assessing her or his own progress?
8. How can you involve this patient in monitoring her or his own condition?
9. What instructions or information does the patient need about medications, diet and exercise in order to follow the treatment plan?
10. How can you help the patient to problem solve how to cope with the barriers s/he has encountered in carrying out the treatment plan?
11. What symptoms and sensations did you tell the patient to expect as a result of following the treatment plan?
12. What role did the patient play in deciding on the treatment plan?
13. How much has this patient been asked to do at once?
14. Which part(s) of the treatment plan is(are) most important to the patient's well being?
15. How can you involve the patient in adapting the treatment plan to fit her or his needs?
16. What has the patient told you previously about her or his attitude and/or feelings about the condition and/or treatment plan?
17. Do the patient's comments reflect any attitudes or feelings of which you were unaware?

18. If the patient seems to be angry, depressed or denying, are the patient's feelings more or less noticeable than on previous occasions?

19. What kind of consult or assistance, if any, might assist this patient to adjust to her or his condition? (social worker, peer support group, more information about condition)

20. Have you met with the patient's family to explain the condition and/or the importance of the treatment plan?

21. What support, assistance or information do you believe the patient's family needs?

22. How can you help ease any financial burden the condition and/or treatment plan is placing upon the patient (samples of medications, alternative medications, social service resources, etc.)?

Use these questions as a general guide to your discussion with the resident. Some of the questions may be inappropriate for a particular patient interview; you may wish to add questions to this list. Each of the questions suggests patient education strategies.

Clearly, all of the strategies listed above could not be implemented in one visit. Work through the following steps with the resident to develop a long-term patient education plan for the interviewed patient:

1. Identify the tasks that need to be accomplished;

2. Put these tasks in order of priority, taking into consideration both medical exigencies and the patients needs;

3. Make a reasonable estimate of the amount of time needed to complete each task;

4. Write out a long term plan and insert the plan into the patient's medical record.

SEMINAR FOR MODULE 5

THE USE OF A CHART REVIEW TO INITIATE DISCUSSION OF PATIENT EDUCATION REQUIREMENTS FOR LONG-TERM CONDITIONS

The patient with a chronic disease must make many physical and psychological adjustments in response to diagnosis and treatment (see Strauss, 1975). Such patients clearly have an ongoing need for information and for support to enable them to continue the daily management of their own care. The physician can assist the chronically ill patient more effectively by assessing the individual patient's perception of the illness and treatment, by enlisting nurses and other supportive health professionals, and by using a medical record system that facilitates an ongoing program of patient education.

This seminar uses the example of chronic essential hypertension to explore some of the issues of the physician's role in assisting the patient to manage chronic illness. Hypertension is presented because it:

1. Is a relatively asymptomatic chronic disease with potentially catastrophic consequences;
2. Can be effectively controlled with long-term adherence to a clearly specified medical protocol;
3. Is a common patient problem.

A review of the resident's own medical charts for patients with hypertension is discussed to demonstrate the relationship between medical charting and the ability to manage ongoing problems effectively. Finally, generalizations to other chronic conditions are discussed.

The seminar can be presented as one two-hour seminar, or two shorter seminars. If two seminars are preferred, chart review data can be presented first, followed by a discussion of implications and generalizations.

OBJECTIVES

The resident will discuss the importance of:

1. Establishing agreement with the patient about the diagnosis;
2. Assessing and sharing with the patient physiological changes in specific terms (e.g., blood pressure, weight, etc.);
3. Engaging patient in an active role in selecting educational methods and carrying out regimen; e.g., charting own blood pressure;
4. Identifying family members and friends who can assist patient in following the treatment plan;
5. Documenting patient education for chronic conditions.

PREPARATION OF THE SEMINAR LEADER

The seminar leader should be familiar with the issues in the adaptation of patients to chronic illness and the potential role of the physician in assisting the patient. These issues include the psychological impact, such as depression or anger, of a chronic illness diagnosis, the changes in family and work patterns necessitated by long-term illness and treatment, the overwhelming amount of information about the condition and its effective treatment that must be provided to the patient, and the complex behavioral issues involved in changing and sustaining changes in lifelong habits.

An excellent introduction to this area is Aiken's chapter, "Chronic Illness and Responsive Ambulatory Care" (1976). Strauss' book, Chronic Illness and the Quality of Life (1975), also presents a thorough discussion of the problems of living with chronic disease, and provides illustrations of the implications of specific chronic illnesses including ulcerative colitis, rheumatoid arthritis and emphysema. Once again, Lear's book, Heartsounds presents a detailed picture of one patient's struggle to adapt to a chronic condition (see Module 2).

Specific problems in adaptation to hypertension illustrate problems that are found in adaptation to other diseases. For example, Meyer (1980) found that newly diagnosed hypertensives tend to assume that their condition is similar to an acute disease that would be quickly cured. Only after repeated visits, and frequently following a period of covert experimentation with the treatment plan, do patients begin to become convinced that the condition is a chronic one requiring long-term treatment. Studies of adherence to antihypertensive treatment plans in a variety of settings (McKinney et al., 1973; Haynes et al., 1978) appear to demonstrate that hypertensives have a need for ongoing information and regular medical contact to maintain adherence and blood pressure control.

The Hypertension Chart Audit described at the end of the seminar also provides background for the seminar. The usefulness of each category of information on the chart review is explained. This document can be altered appropriately and used for designing educational plans for patients with other chronic conditions (see the Weight Loss Chart Review in Module 4).

The most time-consuming part of preparing for this seminar is the actual review of medical records. Records for review can be identified by selecting charts randomly from a computer listing of hypertensive patients, selecting hypertensive patients from a consecutive listing of patients seen in the clinic, or obtaining lists of hypertensive patients from each resident. The first method is preferable if a computerized listing is available because it permits the equal inclusion of hypertensive patients seen both frequently and rarely. Reviewing a consecutive list of patients overselects those patients seen frequently, while selection by resident suggestion introduces the bias of memory and the desire to be reviewed in a favorable light.

Charts can be reviewed by using the Hypertension Chart Review Instruction Pamphlet (see Appendix 1). An effort should be made to review at least two charts of patients seen regularly by each resident who will be participating in the seminar.

Charts can be reviewed by residents, faculty, or by a trained reviewer. If a nonmedical chart reviewer is used, the charts should be checked periodically for accuracy and understanding of medical terms.

Data from the chart reviews can then be tallied on summary sheets (see Summary Table, page 229). It is also helpful to copy examples of individual notes which meet specific chart review criteria, such as an adherence assessment note or education materials supplied to patient, and other areas where documentation is often neglected.

SEMINAR OUTLINE

I. Introduction

  A. Chronic illness treatment differs from acute illness care.

    1. The need for long-term care and the absence of cures are difficult to understand and accept for both patient and physician (Strauss, 1975). These facts must be discussed and reinforced during initial diagnosis and treatment of chronic conditions.

    2. Patients may fluctuate between good health and serious relapses; e.g., patients with diabetes or congestive heart failure. In progressive diseases, a patient may relapse despite strict adherence to treatment. Continuing support and education about the course of the condition and of the treatment enable patients to cope with relapses effectively.

    3. Effective care for chronic conditions requires active participation of the patient. For example, Shulman (1979) argued that active patient participation in selecting treatment behaviors and rewards for those behaviors was an important determinant of long-term adherence in one high blood pressure study.

  B. In addition to providing appropriate medical management of chronic conditions, the physician must develop a patient education plan that includes long-term support, encouragement and information. The physician, a nurse practitioner or other clinic staff can carry out this plan. This task is facilitated by a record system, such as a chart flow sheet, that is designed to structure, plan and document long-term patient education strategies.

II. The Hypertensive Patient - Planning for Long-Term Care

  A. Is educational planning necessary?

    1. Although the typical antihypertensive drug regimen appears simple, many patients fail to follow the treatment plans closely (see Module 3, Seminar 1; Sackett and Haynes, 1976). A number of explanations have been proposed: lack of knowledge or instruction, inconvenience and side effects.

2. Many patients drop out of treatment (see Finnerty et al., 1973). Meyer (1981) found that patients often report dropping out because they feel cured. Simple one-shot educational strategies such as the use of support groups have been shown to be ineffective (Levine et al., 1979). Patients are more likely to remain in treatment when they have regularly scheduled clinical contact (Haynes et al., 1979).

B. What are the components of a long-term educational plan to keep hypertensive patients in care?

The physician must provide information on:

1. The condition.
    a. Name.
    b. Cause-etiology.
    c. Anticipated course of disease.
    d. Consequences of treating and not treating the condition.
2. Concrete, short-term outcomes that the patient can use to judge success of treatment.
    a. Graph of the patient's blood pressure values as well as the normal range of blood pressure.
    b. Expected physical sensations of medications, such as frequent urination, that should be interpreted as signs that medicine is working.
3. Nature of blood pressure treatment.
    a. No single treatment works for everyone.
    b. Individualize medical treatment.
    c. The optimal medical regimen is adapted to daily habits of the patient (see Module 3).
4. Solutions for typical adherence problems.
    a. Forgetting medicine; developing a reminder system helps patients remember.
    b. Instruct the patient to call to alter the regimen when s/he encounters noxious side effects.
    c. Discuss openly that everyone has a natural tendency to cut back or experiment with treatment plans.
5. Ways that the patient can be actively involved in her or his own care.
    a. Additional blood pressure measurements recorded by the patient enable her or him to monitor treatment progress at home or at work.
    b. Exercise programs and dietary changes for reducing salt intake or weight can be suggested as supplemental treatments so that the patient can select part of the treatment plan.

6. Mechanisms for ongoing reinforcement and support.

   a. Frequent visits (phone calls) to the physician or nurse.
   b. Involve family members to provide support and assistance.

C. At this point discuss relevance of this list to other conditions.

   1. Cardiac conditions (e.g., Aiken, 1976).

   2. Diabetes (Espenshade, 1979).

   3. Others.

D. Present criteria on Hypertension Chart Review Protocol. (Show transparency of blank protocol; encourage discussion of feasibility of recording this kind of data in the chart.) For individual justifications of categories, see Appendix I.

   1. The following categories should be assessed and recorded at each clinic visit of a hypertensive patient.

      a. Blood pressure reading.
      b. Weight.
      c. Medication.
      d. Compliance assessed.
      e. Note about blood pressure control.
      f. High Blood Pressure Flow Sheet updated.

      Rationale: Repeated monitoring and appropriate reinforcement of these factors by the physician emphasizes the importance of the long-term treatment plan. Every clinic visit (regardless of the reason for that visit) provides an opportunity for a brief discussion of blood pressure and thus serves as a reminder of the importance of blood pressure control.

   2. The following categories should be assessed and recorded at least once during treatment and preferably should be updated yearly.

      a. Daily activities
         (1) Patterns
         (2) Diet
         (3) Salt intake
         (4) Exercise
      b. Knowledge of condition
      c. Burden of cost of treatment
      d. Impact on life

      Rationale: Assessment of these factors is important to developing a workable plan with the patient (see Module 3; Seminar 2). Besides providing important data, documentation of these factors eliminates the potential for redundant assessments in visits, especially in group practices such as residencies, where a patient may be seen by many different physicians.

3. The following educational interventions should be recorded in the chart, preferably early in the treatment process:

    a. Physiology explained.
    b. Need for regular visits discussed.
    c. Weight linked to blood pressure.
    d. Stress linked to blood pressure.
    e. Salt linked to blood pressure.
    f. Exercise linked to blood pressure.
    g. Medicine instructions on list to patient.
    h. Other written blood pressure instructions.
    i. Follow-up visit set (not PRN).
    j. Behavior plan established.

    Rationale: Educational interventions should be documented to avoid omission or repetition of important information. This is especially true when the information must be presented over several visits. A simple physiological explanation of high blood pressure justifies the need for regular visits to adjust medication. Depending upon the treatment plan for the individual patient, other educational interventions should also be presented, such as weight, stress, salt, and exercise, so that the patient understands how these treatments affect blood pressure. In chronic conditions like high blood pressure where drug regimen is frequently altered, written medication instructions at each visit can dramatically increase adherence (Svarstad, 1974). A specific follow-up appointment date established at the visit is also important as it stresses the need for regular contact. Finally, in individual cases, a behavior plan should be established to assist patients who have difficulty with some of the plan, e.g., to increase exercise, suggest a 15 minute walk after lunch in a nearby park; to remind a patient about twice-daily medications, suggest keeping pills in kitchen to take with morning and evening meals. This is simply a means of providing clear and simple instructions.

III. Present Review Results with Discussion

A. Present summary table of Hypertension Chart Review results on overhead projector. Allow residents time to review data. (See sample Summary Table of chart data from residency p.229).

B. Discuss Table.

1. What data look good, what is being done well? (e.g., in sample table, pattern of daily activities was assessed for 55% of patients.)

2. What do you think should be improved? (e.g., follow-up visits should be scheduled more often than 36% of the time).

PATIENT EDUCATION
CHART AUDIT - HYPERTENSION

SUMMARY TABLE

DATA:	Expected Frequency of Performance	No. Pts.	Yes	Yes %	Some-times	Some-times%	No	No %
BP Reading	All	61	54	88%	7	11%	0	0%
Weight	All	61	46	75%	15	24%	0	0%
Compliance assessed	All	61	6	9%	34	55%	21	34%
Note about BP	All	61	32	52%	28	45%	1	1%
Hypertension flow sheet updated	All	61	5	8%	9	14%	47	77%
Daily activities assessed:								
- Pattern	1	61	34	55%	N/A		27	44%
- Diet	1	61	34	55%	N/A		27	44%
- Salt intake	1	61	13	21%	N/A		48	78%
- Exercise	1	61	12	19%	N/A		49	80%
Knowledge of condition assessed	1	61	5	8%	N/A		56*	91%
Burden of cost of medications	1	61	0	0%	N/A		61	100%
Impact on life assessed	1	61	2	3%	N/A		59	96%
INTERVENTION:								
Physiology explained	1	61	2	3%	N/A		59	96%
Need for regular visits discussed	1	61	4	6%	N/A		57	93%
Weight linked to BP	1	61	17	27%	N/A		44	72%
Stress linked to BP	1	61	2	3%	N/A		59	96%
Salt linked to BP	1	61	19	31%	N/A		42	68%
Exercise linked to BP	1	61	6	9%	N/A		55	90%
Other teaching re: BP	1	61	28	45%	N/A		33	54%
Written instructions for BP medications	All	61	2	3%	26	42%	33	54%
Other written instructions (re: BP)	1+	61	39	63%	13	21%	9	14%
Follow-up visit set (Not PRN)	All	61	22	36%	39	63%	0	0%
Behavior plan established	1	61	10	16%	N/A		49*	80%

* 2 missing data.

Instructional Modules to Teach Primary Care Residents to Educate Patients. By
University of Wisconsin,
Department of Family Medicine and Practice
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3. Are there ways we can make improvements easier to do? Suggestions might include:

    a. Develop flow chart for patient education for hypertension.
    b. Note when we give handouts.
    c. Make sure medical assistants routinely record blood pressure.

4. What are some ways you have used with hypertensive (or other chronic illness) patients to note educational activities? (Leader can share some examples from the review).

IV. Summary (Let residents make summary statements).

A. What generalizations can we make about the ongoing educational care of the chronic illness patient?

B. What conclusions can we draw from the chart review data about documenting patient education in chronic conditions? How does your record keeping reflect the complexity of the process the patient is going through? Would your notes be helpful to a colleague? How can you simplify your note taking but still record important information?

C. How can you assist the patient to manage a chronic condition?

1. How do you simplify treatment plans?

2. How do you involve the family and friends of the patient?

3. Is there a way you can help patients prepare for crises?

4. Do you think your chronic disease patients can rely on you for support? Do you have time to provide this support? Can others on the health care team provide it?

THE ROLE OF THE CLINICAL FACULTY FOR MODULE 5

The primary care physician must be prepared to meet the complex educational challenge of treating patients with chronic illnesses. In addition to the patient education skills presented in the preceding modules, the physician must develop long-term education plans which help patients anticipate problems and cope with the disease and its treatment.

The experienced physician has seen the difficult problems that the chronically ill patient's face and has developed strategies to assist the patient to overcome these problems.

The activities in Module 5 are designed to teach the resident to:

1. Establish agreement with the patient about the diagnosis;
2. Present a manageable amount of information to the patient;
3. Assess and share with the patient physiological changes;
4. Provide the patient with an opportunity to talk about general attitudes, fears and depression concerning condition;
5. Engage the patient in an active role of selecting educational methods and carrying out treatment plan;
6. Assess influence of relevant environmental situations, e.g., employment status, work conditions and work schedule, on the patient's ability to adapt to a long term condition.
7. Assess patient adherence to previous treatment plans.

METHODS OF TEACHING PATIENT EDUCATION SKILLS IN THE OUTPATIENT CLINIC

1. *Establish agreement with the patient about the diagnosis.*

Simply giving the patient a diagnostic label for her or his condition can create anxiety or confusion. After the label is explained in simple terms, the patient should be asked about what the condition means to her or him. This creates an opportunity to assess the patient's understanding of the diagnosis and to establish agreement on it. Unless agreement is reached, the patient may not understand the need for following a treatment plan.

When seeing a patient with the resident, you can ask the patient her or his understanding of the diagnosis: "What do you know about asthma?" "What does having asthma mean to you?" "Have any of your family or friends had asthma?"

When discussing a patient with a resident, ask the resident to describe how s/he explained the diagnosis and if the patient understood or agreed with it. These questions demonstrate your concern that patients understand their condition.

2. *Present a manageable amount of information to the patient.*

Adequate explanation of diagnosis and treatment of a chronic illness requires a great deal of detailed information. Patients have difficulty retaining large amounts of information, and therefore a single "marathon" educational session about an illness will probably result in later repetitions and subsequent physician and patient frustration. Several brief educational visits over a short period of time supplemented by written material allow the patient to assimilate the diagnostic and treatment information more easily.

When discussing a patient with the resident, ask which educational tasks are being addressed at the visit. If several topics are mentioned by the resident, such as the physiology of diabetes, its consequences, and its treatment, including foot care, you can point out the problem a patient might have remembering all this information. You can suggest a series of educational visits so that each topic can be fully addressed.

3. *Assess and share with the patient physiological changes in specific terms; e.g., blood pressure and weight.*

Patients have a right to basic medical information, and they become more actively involved and interested in their care when they are told physical findings in specific and understandable terms. "Your blood pressure is okay" can reassure one patient but cause concern in another: "It's just okay?" A physician provides a hypertensive patient with specific feedback about treatment progress when s/he tells the patient what her or his actual blood pressure reading is, and then compares that reading to the patient's goal blood pressure reading. "Your blood pressure is 168/95 today. You are getting close to the acceptable blood pressure for a person your age, 140/90." The use of a graph to chart a patient's weight or blood pressure at each visit also shows the patient how treatment is progressing.

If you see a hypertensive patient with the resident, you can tell the patient the blood pressure reading and compare it to a normal or goal pressure.

When consulting with a resident about a patient who is dieting, ask the physician how much weight the person has lost since the beginning of the diet and whether or not the patient is given this information at each visit. This asserts your belief in the importance of assessing and discussing physiological changes in specific terms.

4. *Provide the patient with an opportunity to talk about general attitudes, fears and depression concerning condition.*

A chronic illness can be frightening and depressing to a patient. Opportunities to discuss these feelings, and reassurance that such feelings are commonly experienced by others help patients to cope with chronic illness. The physician can often correct misunderstandings and provide reassurance. For example, the memory of a grandfather who suffered a severe stroke can cause needless anxiety in the mildly hypertensive patient. Unless these attitudes and fears are discussed, patients may avoid or delay treatment, suffer needlessly or become obsessed with their condition.

When discussing a patient who has a chronic illness, ask the resident how the patient is coping with the condition or treatment. Suggest ways in which the resident can approach the patient: "Many people who have a chronic illness become depressed or frustrated. What impact has your condition had on you?"

5. *Engage the patient in an active role of selecting educational methods and carrying out treatment plan.*

Recent studies have shown that patients are more likely to remain in treatment and follow a treatment plan if they are involved in selecting and adapting the treatment plan to their particular situation.

Treatment plans for chronic illnesses involve major behavior and lifestyle changes. Such changes are difficult for many patients to accept and/or implement. It is especially important to involve patients who have a chronic illness in decisions about their treatment plans. This involvement enables patients to exert some control over the impact of chronic illness on their lives. Patient's are also uniquely able to identify which components of a treatment plan they are willing or capable to perform and which components will fit into their daily schedule or lifestyle.

When seeing a patient with a resident, enlist the patient's involvement in choosing treatment options. When discussing a patient with a resident, suggest alternative treatment methods for chronic conditions that the resident can offer to patients, such as dietary restrictions and exercise versus medications for mild hypertension.

6. *Assess influence of relevant environmental situations, e.g., employment status, work conditions and work schedule, on the patient's ability to adapt to a long term condition.*

The limitations imposed on a patient by a chronic illness and the complex medical treatment that is often required can have profound effects on the patient's everyday life. An individual patient's lifestyle, work, and family situation must be assessed in order to assist the patient to adapt to chronic illness. A chronic heart condition might have little effect on the continued employment of a person with a desk job. The same condition might totally disable a manual laborer. Work schedules can also be important to adapting to an illness. The flexible schedule of a sales person might easily be adjusted to periodic "flare-ups" of arthritis, but the same condition might disable an executive who must always be available.

When seeing a patient with the resident, you can ask the patient:

"What do (or did) you do each day?" "How has the condition or its treatment affected your work or other activities?"

When discussing a patient with the resident, ask her or him how the illness or its treatment has affected the patient's work or home situation. Asking this question demonstrates the importance you place in assessing environmental factors such as work and everyday activities which can assist or inhibit a patient's adaptation to a chronic condition.

7. *Assess patient adherence to previous treatment plans.*

When adherence to ongoing treatment plans is not assessed, the patient may assume that the plan was not important to the physician. When adherence to previous plans is not assessed, difficulties the patient had in following the plan may be repeated in subsequent treatment plans. Regular assessment of adherence emphasizes the importance of following the plan and can uncover problems with the plan which need to be addressed, such as annoying side effects, scheduling conflicts, or simply misunderstanding of instructions.

When seeing patients with the resident, ask open-ended questions about adherence which encourage accurate reports:

> "Many people have trouble taking daily medications...What problems do you have?"
>
> "What dose (or kind of medication) are you most likely to miss?"
>
> "What do you do when you miss a pill?"
>
> "What problems did you have with the back exercises last time?"
>
> "Where did you do the exercises? How did that work out?"

These questions can give you valuable information about how the treatment plan is working or worked before. Solutions to problems can usually be suggested, such as altering the plan to better fit the patient schedule, changing the medication to reduce unwanted side effects, or providing some kind of reminder system for the patient. Unless adherence has been assessed, however, problems are never identified.

APPENDIX I

HYPERTENSION CHART REVIEW

INSTRUCTION PAMPHLET

IDENTIFICATION OF CHARTS FOR REVIEW

There are several methods of identifying appropriate charts for review. If a computerized problem list is kept for residency clinic patients, a computer search can be used to identify appropriate charts for review. Ask for a printout which lists:

1. Names of all patients whose problem lists include hypertension.
2. The name of each patient's resident physician.
3. The identification number for each patient.

The daily appointment books maintained by the clinic receptionists can also be used to obtain patient names. Make a list of patients for whom hypertension or blood pressure check is listed as the reason for visit. This technique is sometimes unreliable. Hypertensive patients do schedule appointments for acute call, in which case hypertension is not likely to be listed as the reason for visit. As a supplement to the first two techniques of chart identification, ask nurses and residents to list names of patients the residents are treating for hypertension.

INSTRUCTIONS FOR USE OF CHART REVIEW PROTOCOL

CHART IDENTIFICATION SECTION

Date of the Chart Review

Record the date that the chart review is performed.

Responsible Resident

For the purpose of the chart review, the responsible resident is the resident who saw the patient about hypertension for the greatest number of visits.

Determining an Initial Visit Date

Once you have determined the patient's name, pull the patient's chart and find the visit at which hypertension was first recorded as a problem. If the date of that visit is less than one year before the date of the chart review, begin the review at that visit. If the date of that visit is more than a year before the date of the chart review, begin the review at the visit which is approximately one year before the date of the review.

Examples:

Chart Review Date	Obesity First Recorded	Initial Visit Date
1/1/80	6/11/79	6/11/79

Chart Review Date	Obesity First Recorded	Initial Visit Date
1/1/80	6/11/78	visit closest to 1/1/79

Review every visit made by the patient beginning at the initial visit date and continuing through the date of the chart review. Every column on the "Hypertension Chart Review Protocol" corresponds to one visit. The following are instructions for each row:

ENCOUNTER INFORMATION SECTION

Visit Date

Record the date of the visit being reviewed.

Main Purpose of Visit

Record the reason the patient has come to the clinic for the visit. This information is usually available in the appointment book or at the top of the progress notes in the chart.

M.D.

Record the name of the resident who saw the patient at this visit. This resident might not be the "responsible resident."

The column marked "Expected Frequency of Performance" specifies the number of visits at which information pertaining to the chart review criteria should be recorded:

All	Ideally, this information should be recorded at least once.
1+	Ideally, this information should be recorded more than once.
1	Ideally, this information should be recorded once.

DATA SECTION

The symbols used to record data are + and 0. When the progress notes in a chart indicate that a criterion was not met for a specific visit, record 0.

Visit Date		2/28
Main Purpose of Visit		BP check
M.D.		Lesing
DATA:	Expected Frequency of Performance	
BP Reading	All	168/114
Weight	All	205
Compliance assessed	All	0

In this example, 0 signifies that the progress notes for February 28 do not indicate that compliance was assessed. When the progress notes for a visit indicate that a criterion was met, record a +.

BP Reading

Record all blood pressure readings. If possible, record how the readings were taken. For example, if a reading of 130/90 was taken with the cuff on the right arm while the patient was sitting, you might record that as: "130/90 rt. arm sitting." This should be recorded at each visit. If you cannot find the blood pressure reading in the progress notes for a particular visit, check the patient's hypertension flow sheet. If no blood pressure reading is written in the progress notes, record 0 on the chart review protocol.

Weight

Record the patient's weight for the visit. If the patient's weight has not been entered, record 0. This should be recorded at each visit.

Compliance Assessed

Record whether or not the resident has assessed patient compliance with life-style changes or medications. This should be recorded at each visit. If the progress notes indicate that the resident has assessed compliance, record +. If the progress notes indicate that the resident has not assessed compliance, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient edematous	0
Taking pills - no side effects didn't like K Cl	+
Out of meds.	+

Note about Blood Pressure

Record whether or not the resident made a comment about blood pressure during a visit for a problem other than blood pressure. This should be recorded at each visit. If the progress notes indicate that the resident made a comment about blood pressure, record +. If the progress notes indicate that the resident did not make a comment about blood pressure, record 0. For example:

Comment in Chart	Record on Chart Review Protocol
Blood pressure under control	+

Hypertension Flow Sheet Updated

Record whether or not the resident has updated the patient's hypertension flowsheet for this visit. This should be recorded at each visit. If the hypertension flow sheet was updated for this visit, record +. If the hypertension flow sheet was not updated for this visit record 0.

Daily Activities Assessed: Pattern

Record whether or not the resident has assessed the patient's daily routines: lifestyle, work hours, schedule. This should be recorded at least once. If the progress notes indicate that the resident has assessed the patient's daily routines, record +. If the progress notes do not indicate that the resident has assessed a patient's daily routines, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient walks to work regularly	+
Patient on swing shift	+
Patient travels a lot for work, works long hours	+

Daily Activities Assessed: Diet and Salt Intake

Record whether or not the resident has assessed a patient's daily eating habits. This should be recorded at least once. If the progress notes indicate that the resident has assessed the patient's daily eating habits, record +. If the progress notes do not indicate that the resident has assessed the patient's daily eating habits, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient has eliminated eggs, red meat, fowl from diet	+
Patient has poor eating habits	0
Patient uses low calorie recipes, diet soda, sugar substitute	+
Patient eats donuts for breakfast, lunch at McDonald's, TV dinners	+

Daily Activities Assessed: Salt Intake

Record whether or not the resident has assessed a patient's salt intake. This should be recorded at least once. If the progress notes indicate that the resident has assessed a patient's salt intake, record +. If the progress notes do not indicate that the resident has assessed a patient's salt intake, record 0. For example:

300

Comment on Chart	Record on Chart Review Protocol
Patient not adding salt to his food	+
Doesn't like salt substitutes; weight increase 4 lbs. in 1 month	+

Daily Activities Assessed: Exercise

Record whether or not the resident has assessed a patient's daily exercise. This should be recorded at least once. If the progress notes indicate that the resident has assessed a patient's daily exercise, record +. If the progress notes do not indicate that the resident has assessed a patient's daily exercise, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Active about house	0
Walking 30 minutes every day	+
Belong to health club: weight training, swimming and 20 minute exercise class 4 times a week	+
Jogs episodically	+
Hates exercise - never walks	+

Knowledge of Condition Assessed

Record whether or not the resident has assessed the patient's perception of hypertension. This should be recorded at least once. If the progress notes indicate that the resident has assessed the patient's understanding of hypertension, record +. If the progress notes do not indicate that the resident has assessed the patient's understanding of hypertension, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient understands connection between diet and increased blood pressure	+
Patient stopped meds; she didn't see need to continue meds	+
Patient's mother has high blood pressure	0
Much patient education required, unwilling to see illness as chronic	+
She doesn't understand the need to lose weight	+

Burden of Cost of Medications

Record whether or not the resident has assessed to what extent the cost of medications is a financial burden to the patient. This should be recorded at least once. If the progress notes indicate that the resident has assessed to what extent the cost of medications is a burden to the patient, record +. If the progress notes indicate that the resident has not assessed to what extent the cost of medications is a burden to the patient, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Insurance will pay for meds	+
Samples given - patient can't afford meds	+

Impact on Life

Record whether or not the resident has assessed the impact on a patient's life of the diagnosis and treatment of hypertension. This should be recorded at least once. If the progress notes indicate that the resident has assessed the impact on a patient's life of the diagnosis and treatment of hypertension, record +. If the progress notes indicate that the resident has not assessed the impact on a patient's life of the diagnosis and treatment of hypertension, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient unwilling to see illness as chronic	+
Patient overwhelmed by treatment plan	+

INTERVENTION SECTION

Physiology Explained

Record whether or not the resident has explained the physiology of hypertension to the patient. This should be recorded at least once. If the progress notes indicate that the resident has explained the physiology of hypertension to the patient, record +. If the progress notes do not indicate that the resident has explained the physiology of hypertension to the patient, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Rationale of treatment discussed	+

(cont.)

Explained meaning of hypertension	+
Talked about what hypertension is	+
Patient told treatment will be lifelong	0

Need for Regular Visits Discussed

Record whether or not the resident has explained the importance of regular visits in the treatment of hypertension. This should be recorded at least once. If the progress notes indicate that the resident has discussed the necessity of regular visits, record +. If the progress notes do not indicate that the resident has discussed the necessity for regular visits, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Discussed need to follow meds	+
Encouraged patient to see doctor regularly	0
Explained importance of frequent blood pressure checks	+

Weight Linked to BP

Record whether or not the resident has discussed with the patient the relationship between overweight and hypertension. This should be recorded at least once. If the progress notes indicate that the resident has discussed the relationship between overweight and hypertension, record +. If the progress notes do not indicate that the resident has discussed the relationship between overweight and hypertension, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient told that weight decrease should decrease BP	+
Patient told might be able to avoid taking meds if loses weight	+
Patient told if doesn't lose weight, will have to increase meds	0

Stress Linked to BP

Record whether or not the resident has explained the effect of stress on blood pressure. This should be recorded at least once. If the progress notes indicate that the resident has explained the effect of stress on blood pressure, record +. If the progress notes do not indicate that the resident has explained the effect of stress on blood pressure, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Discussed importance of stress reduction to BP	+
Explained impact of stress on BP	+
Patient told to avoid stress	0

Salt Linked to BP

Record whether or not the resident has explained the relationship between salt intake and hypertension. This should be recorded at least once. If the progress notes indicate that the resident has explained the relationship between salt intake and hypertension, record +. If the progress notes indicate that the resident has not explained the relationship between salt intake and hypertension, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient told: if decrease salt use, might avoid meds	+
Discussed relationship between BP and salt	+
Told patient to use salt substitute	0

Exercise Linked to BP

Record whether or not the resident has explained the relationship between exercise and blood pressure. This should be recorded at least once. If the progress notes indicate that the resident has explained the relationship between exercise and blood pressure, record +. If the progress notes indicate that the resident has not explained the relationship between exercise and blood pressure, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Told patient to get more exercise	0
Discussed need for regular exercise	+
Explained importance of aerobic exercise	+

Other Teaching Re: Blood Pressure

Record whether or not the resident has given the patient any other information about hypertension, including:

1. The use of blood pressure cuff
2. Salt substitutes
3. Weight-loss and salt-free diets
4. The effect of birth control pills on hypertension

This should be recorded at least once. If the progress notes indicate the resident has given the patient any other information about hypertension, record a +. If the progress notes indicate that the resident has not given the patient any other information about hypertension, record a 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient given home BP cuff and instructed on its use	+
Explained blood tests	0
List of readings provided	+
Relaxation therapy discussed	+
Salt substitutes listed	+

Written Instructions Re: BP Medications

Record whether or not the resident gave the patient written instructions for any antihypertensive medications prescribed. This should be recorded at each visit. If the progress notes indicate that the patient is not taking any antihypertensive medications, record N/A. If the progress notes indicate that the resident gave the patient written instructions for antihypertensive medications record +. If the progress notes do not indicate that the resident gave the patient written instructions for antihypertensive medications, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Clonidine - orange pills - continue 1 in a.m., 2 in p.m.	+
Apresaline - yellow pill - 2 in a.m., 2 in afternoon, 2 at night	+

Other Written Instruction (re: BP)

Record whether or not the resident has given the patient written instructions other than medication instructions, about blood pressure. This should be recorded more than once. If the progress notes indicate that the resident has given the patient other written instructions about blood pressure, record +. If the progress notes do not indicate that the resident has given the patient other written instructions about blood pressure, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Take home BP readings daily for next 2 weeks	+
Read labels on foods for salt content	+
Read Barbara Gibbons' Slim Gourmet Cookbook for low calorie, low cholesterol recipes	+

Follow-Up Visit Set

Record whether or not the resident has set a specific date for a follow-up visit for hypertension. This should be recorded at each visit. If the progress notes indicate that the resident did set a specific date for a follow-up visit, record +. If the progress notes indicate that the resident did not set a specific date for a follow-up visit, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Patient to come in for BP check 3-4 times in next month	0
Told to make appointment for return visit	0
Patient to return for BP check in 2 weeks	+
Patient told to make appointment for next Wednesday	+

Behavior Plan Established

Record whether or not the resident helped a patient to develop a specific behavior plan. This should be recorded at least once. If the progress notes indicate that the resident helped a patient to develop a specific behavior plan, record +. If the progress notes do not indicate that the resident helped a patient to develop a specific behavior plan, record 0. For example:

Comment on Chart	Record on Chart Review Protocol
Take daily BP reading	+
Walk 30 minutes every day	+
Add no salt to food	+

(cont.)	Take medication at breakfast, lunch and dinner	+
	Limit food intake to 1400 calories per day	+
	Lose weight	0
	Decrease salt	0

CHART REVIEW - HYPERTENSION

Patient ____________

Chart No. ____________ Responsible Resident ____________

Age _____ Height _____ Date ____________

Visit Date								
Main Purpose of Visit								
M.D.								
DATA:	Expected Frequency of Performance							
BP Reading	All							
Weight	All							
Compliance assessed	All							
Note about BP	All							
Hypertension flow sheet updated	All							
Daily activities assessed:								
- Pattern	1							
- Diet	1							
- Salt intake	1							
- Exercise	1							
Knowledge of condition assessed	1							
Burden of cost of medications	1							
Impact on life assessed	1							
INTERVENTION:								
Physiology explained	1							
Need for regular visits discussed	1							
Weight linked to BP	1							
Stress linked to BP	1							
Salt linked to BP	1							
Exercise linked to BP	1							
Other teaching re: BP	1							
Written instructions for BP medications	All							
Other written instructions (re: BP)	1+							
Follow-up visit set (Not PRN)	All							
Behavior plan established	1							

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Department of Family Medicine and Practice
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CHART REVIEW - HYPERTENSION

Patient Martha Quest
Chart No. 432-5334
Age 30 Height 5'3"

Responsible Resident Lesing
Date 8/8/80

Visit Date		5/31/80	6/3/80	7/8/80	7/20/80			
Main Purpose of Visit		BP check	BP check	Earache	BP check			
M.D.		Holden	Lesing	Lesing	Lesing			
DATA:	Expected Frequency of Performance							
BP Reading	All	170/106	172/104	158/95	148/98			
Weight	All	200	205	195	191			
Compliance assessed	All	0	+	0	0			
Note about BP	All	+	+	0	+			
Hypertension flow sheet updated	All	+	+	0	0			
Daily activities assessed:								
- Pattern	1	0	+	0	0			
- Diet	1	0	+	0	0			
- Salt intake	1	0	0	0	0			
- Exercise	1	0	0	0	+			
Knowledge of condition assessed	1	0	+	0	0			
Burden of cost of medications	1	0	0	0	0			
Impact on life assessed	1	0	0	0	0			
INTERVENTION:								
Physiology explained	1	0	0	0	0			
Need for regular visits discussed	1	0	+	0	0			
Weight linked to BP	1	+	0	0	0			
Stress linked to BP	1	0	0	0	0			
Salt linked to BP	1	0	0	0	0			
Exercise linked to BP	1	0	0	0	+			
Other teaching re: BP	1	0	0	0	0			
Written instructions for BP medications	All	+	+	0	0			
Other written instructions (re: BP)	1+	0	0	0	0			
Follow-up visit set (Not PRN)	All	+	+	0	0			
Behavior plan established	1	0	0	0	0			

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JUSTIFICATION OF CRITERIA

DATA

Blood Pressure Readings

Blood pressure readings provide data concerning the progress of treatment. The routine measurement of the patient's blood pressure by clinic personnel reinforces its importance at each visit regardless of the reason for the visit. In graph form, this data can show the patient the relationship between everyday behaviors, such as following or not following treatment plans, and specific blood pressure outcomes.

Weight

Weight loss, especially for obese patients, is an important factor in the control of blood pressure. Regular recording of weight provides data about weight loss which can be reinforced or weight gain which can be discussed and addressed.

Compliance Assessed

Questions about compliance provide essential information to supplement medical information. A patient's medication-taking behavior is often significantly different from that prescribed by the physician for many reasons. Unless the patient's behavior is accurately assessed, medications may be inappropriately increased or problems encountered in following the plan may be overlooked. Further, questions about compliance communicate the importance of following the plan. Documenting compliance at each visit can identify patterns of behavior, such as regularly running out of medications or skipping doses, which can be addressed as part of the overall plan.

Note About Blood Pressure

An interpretation of the blood pressure reading (adequate control, etc.) will provide another physician with the primary physician's assessment of treatment progress, and documents rationales for treatment changes.

Hypertension Flowsheet Updated

A flowsheet can save time when one is reviewing previous visits, and when charting. In addition, flowsheets provide a graphic description of the progress of treatment, identifying patterns in weight and blood pressure levels in response to changes in the treatment plan.

Daily Activities Assessed

Pattern. At some point, a patient's daily routines (lifestyle, work hours, etc.) should be assessed. This will provide data about potential barriers or aids to compliance. For example, a patient who rotates work shifts may have difficulty remembering to take medicine as it would be difficult to establish a consistent routine. Documenting these patterns in the chart provides a reminder to the physician to periodically reassess the impact of the barriers or aids.

Diet and Salt Intake. A one time assessment of eating behavior and salt intake will provide data which addresses possible treatment alternatives (need to eliminate foods, reduce calories). A record of this assessment avoids needless repetitive assessment and documents treatment rationales.

Exercise. An assessment of a patient's daily level of exercise can suggest potential interventions to aid in the control of risk factors for the hypertensive patient. Documenting the exercise level can provide useful comparison data for subsequent visits.

Knowledge of Condition Assessed

This data will provide clues for intervention. An accurate (and simple) perception of what hypertension means will justify and reinforce the treatment plan. Furthermore, realistic expectations about treatment outcomes and duration of treatment will promote compliance. Once again documenting this assessment avoids needless repetition and insures agains omitting this important assessment.

Burden of Cost of Medications

Cost is often a significant barrier to compliance, and thus to the outcome of treatment. The burden of the long-term costs of daily medication should be considered with each patient so that economic considerations do not result in poor adherence. Documenting the initial assessment assures that the topic is addressed if cost is a burden and dropped if it is not.

Impact on Life Assessed

To some patients the diagnosis of high blood pressure can be frightening or confusing and can lead to inappropriate restriction of activities or to frantic efforts to return to health. Treatment plans can also alter or disrupt the patient's or her or his family's routines. These issues should be assessed so that any problems are addressed in the course of treatment. Documentation of problems increases the likelihood that they will be periodically reassessed.

INTERVENTION

Physiology Explained

This explanation serves to demonstrate how the blood pressure is lowered by the type of treatment, and to justify the need for it, which in turn promotes compliance. Documentation avoids repetitions or omissions.

Need for Regular Visits Discussed

An explanation of the need for follow-up provides the patient with a rationale for spending the time and the money to keep return appointments. Failure to explain regular follow-up can lead to missed appointments and dropping out. Documenting this discussion can prevent omission or repetition.

Weight/Salt Linked to Blood Pressure

Explaining the links between weight or salt and blood pressure justifies any dietary restrictions or weight control plans suggested to the patient. It is difficult to change eating behavior at any time; it is not likely that a patient will be inclined to do so without connecting the suggested change to the high blood pressure. Documenting the discussion of these links in the chart again protects against omissions or repetitions.

Exercise/Stress Linked to Blood Pressure

The benefit of appropriate stress reduction and increased exercise in reducing health risk factors will provide a justification for changing these behaviors. If the patient is provided with this information s/he will be able to make an informed decision about what s/he can do to assist the treatment and reduce her or his risk factors. By referring to earlier documentation of this discussion, the physician can reinforce those changes in behavior, such as regular exercise, which may be contributing to reductions in blood pressure.

Other Teaching Regarding Blood Pressure

Other teaching would include such things as information pertaining to: the use of a home blood pressure cuff, the usefulness of self-monitoring of blood pressures, available salt substitutes, the effect of the birth control pills on hypertension, etc. Recording this teaching documents that the patient has been provided with information and with strategies to assist in her or his own treatment and to make informed decisions about it.

Written Instructions for Blood Pressure Medications

Written instructions provide a clarification of the treatment plan and give the patient a memory aid. Documenting the instructions provides evidence of a mutual understanding of the plan, and can assist the physician to assess compliance at subsequent visits. (This is not necessary for visits unrelated to hypertension which take place within a week or two of a visit for hypertension.)

Other Written Instructions Regarding Blood Pressure

Written instructions assist a patient to understand and remember what is expected of her or him. Documenting these efforts avoids omission or repetition.

Follow-Up Visit Set (not PRN)

Periodic monitoring of a patient's blood pressure and compliance with the treatment plan is critical to compliance and control of hypertension. Instructions about a specific time to return provide the patient with a clear message about the importance of follow-up, and enhance the probability that the patient will keep the next appointment. Documenting the follow-up visit date provides precise information on missed or rescheduled appointments.

Behavioral Plan Established

This note documents the provision of a specific strategy to follow any treatment plan. Examples would be: to walk 15 minutes every day; to add no salt to food; to take medication at breakfast, lunch and dinner; to limit food intake to 1400 calories per day. This is simply a means of providing clear and simple instructions, which enhance the probability of compliance. Documenting the plan in the chart provides specific information for assessing compliance at subsequent visits and can assist in identifying useful strategies as well as particular problems with the plan.

Instructional Modules to Teach
Primary Care Residents to Educate Patients

MODULE 6

INCORPORATING PATIENT EDUCATION IN PRACTICE

MODULE 6

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INTRODUCTION

When a physician sets up a medical practice, either alone or as part of a group, s/he faces a variety of practical problems. S/He must learn procedures for billing and insurance as well as learn to work with new personnel. In the face of these challenges, it becomes tempting to postpone the development of systems and resources for patient education until "things settle down." In reality, however, things rarely settle down. It is far better for the physician to begin a new practice with a set of guidelines and ideas for patient education than to try to change patterns s/he established early in practice. These guidelines and ideas are adapted from the model clinic setting, where the resident has the opportunity to experiment with education resources and patient flow.

A practice which successfully includes patient education incorporates systems for handling frequently occurring medical problems. These may be as simple as routinely using an American Heart Association pamphlet to supplement patients' understanding of low fat diets, or may involve referring patients with complex educational/medical problems such as diabetes to a nurse or dietician. Good systems are designed to maximize the effectiveness of limited physician time while taking advantage of the value of well designed educational resources or the problem solving skills of other practitioners. In residency training the resident needs to learn options for organizing patient education in practice which s/he can transfer to her/his new practice setting.

The goals for Module 6 are (1) to demonstrate how the principles of patient education, developed in the earlier modules, apply to the design, selection and use of resources for patient education, and (2) to assist the resident to develop systems for materials selection and organization which facilitate the integration of patient education into office practice. The first goal is addressed by seminars on developing patient education handouts and on evaluating audiovisual aids for patient education. The second goal is addressed formally by an activity in which a handout distribution system is designed. This goal is addressed informally as well, by input from faculty physicians and nurse practitioners. The examples set by these role models, in Module 6 and throughout the instructional modules, are most effective for demonstrating the integration of patient education into practice.

OBJECTIVES FOR MODULE 6

Residents will demonstrate an ability to:

1. Develop patient education handouts and protocols;

2. Evaluate commercially prepared patient education resources such as films and pamphlets using explicit criteria;

3. Select instructional materials appropriate for the patient, e.g., labeling of drug containers, pamphlets, films, instruction sheets, etc.;

4. Develop systems to facilitate the use of patient education materials in office practice.

DISCUSSION OF MODULE 6 OBJECTIVES

1. *Residents will develop patient education handouts and protocols.*

Commercially available handouts may not coincide with the physician's preferred method of treatment or may be too expensive for regular office use. If the physician is familiar with principles of communicating clearly in patient education, s/he should be able to apply these principles to the development of simple handouts which meet the special requirements of her or his particular practice. Personal preparation of materials and protocols allows for greater individualization to patient needs and assures that the information is familiar to the physician and accurately reflects her or his current management of the problem.

2. *Residents will evaluate commercially prepared patient education resources such as films and pamphlets using explicit criteria.*

Many kinds of educational materials are commercially available. These materials cover a wide range of problems and vary widely in cost and educational and medical sophistication. In order to make informed decisions about materials and equipment, the physician must be able to evaluate commercially available materials in terms of their educational effectiveness, biases and accuracy (Bosshart, 1977).

3. *Residents will select instructional materials appropriate for the patient, e.g., labeling of drug containers, pamphlets, films, instruction sheets, etc.*

Instructional materials need to be consonant with the patient's educational level, medical sophistication and need for knowledge (Redmond, 1972). The physician needs to avoid the pitfall of using the same instructional approach for each patient by carefully assessing the patient's needs and the value of the instructional material. A film about hypertension may not be of value, for example, for a patient who is not taking her or his medications correctly because of a labeling error, while it might be excellent for a new hypertensive who will be motivated by this information about the condition.

4. *Residents will develop systems to facilitate the use of patient education materials in office practice.*

Patient education materials are only used by and useful to the busy practitioner if they are easily accessible. Examining room files for pamphlets can thus be of benefit to patient and physician. Systems for patient flow should assure adequate follow-up for films and videotapes which may raise patient questions.

SEMINAR FOR MODULE 6

AUDIOVISUAL AIDS FOR PATIENT EDUCATION

Residents often ask: What patient education films should I buy for my practice? This seminar consists of a didactic presentation of advantages and disadvantages of audiovisual aids; an opportunity to screen a patient education film and to evaluate the film with a structured evaluation form; and a group discussion. Residents leave the seminar with a method of critically reviewing audiovisual resources, rather than a list of films that would become rapidly outdated.

Audiovisual materials for patient education are widely marketed; most residents have had an opportunity to view sections of various types of audiovisual programs at professional meetings. Although most patient education videotapes and films are well produced and attractive, they vary widely in terms of content and degree of sophistication. Audiovisual aids perform some of the patient education tasks usually performed by a physician or nurse. Some programs are designed simply to present information about a topic, while others are designed to be "motivational" or to provide suggestions for behavior change.

In this seminar, residents are asked to assess the quality of communication and patient education planning of audiovisual aids, using the same criteria that have been used in earlier modules to assess the resident's patient education skills.

OBJECTIVES

Residents will demonstrate an ability to:

1. Evaluate a patient education film;

2. Identify advantages and disadvantages of using audiovisual materials for patient education.

PREPARATION OF THE SEMINAR LEADER

At least three months before this seminar, request catalogs of films from patient education audiovisual companies:

AUDIO-VISUAL COMPANIES

1. Robert J. Brady, Co.
   Route 197
   Bowie, MD 20715
   Phone (301) 262-6300

2. Medfact, Inc.
   Box 418
   Massillon, OH 44646
   Phone (216) 837-9251

3. Milner-Fenwick, Inc.
   2125 Greenspring Dr.
   Timonium, Maryland 21093
   Phone Toll Free 1-800-638-8652

4. OMNI Education
   190 W. Main Street
   Raritan, N.J. 08876
   Phone (201) 524-1501

5. Professional Research, Inc.
   12960 Coral Tree Place
   Los Angeles, CA 90066
   Phone Toll Free 1-800-421-2363
   or (213) 823-1122

Because primary care residents are potential customers, these companies may be willing to supply films to be previewed for either a minimal charge or no charge at all. You can also request lists of available films from hospitals, medical schools, or health groups, like the American Lung Association.

To provide a representative sample of available films, order at least five films from each of three different sources. Choose topics that are related to primary care, such as hypertension, cystitis, prenatal care, diaphragm use and weight loss. Because many residencies have video monitors, the videocassette may be the simplest film format to use. Eight-millimeter films and filmstrips are formats that are commonly used in practice. Reserve the films for a two-week period. This will assure that the films arrive in time for the seminar.

Schedule two or three rooms for the seminar so that films on several topics can be evaluated simultaneously. Make arrangements to obtain the equipment necessary to view the films. Many audiovisual companies will provide equipment in addition to films. The equipment should be available during the same time period as the films.

Two weeks before the seminar, reconfirm all arrangements: films, equipment, viewing rooms; determine who will operate the audiovisual equipment in each room; and begin to screen all of the films. Use the audiovisual evaluation forms to record your assessment of each film (page 264). This will help you to lead the discussion during the seminar and to give specific examples when describing the advantages and disadvantages of patient education audiovisual aids. Choose the films you will show the residents.

Some criteria for selection:

1. Several different films on the same topic;
2. Films that are exceptionally well done and poorly done;
3. Films in different formats;
4. Films covering several topics.

This seminar lasts approximately sixty minutes if one set of films is shown. Thirty minutes will be needed for each additional set of films that is shown.

PREPARATION OF THE RESIDENT

None.

SEMINAR OUTLINE

I. Introduction

A. The patient education audiovisual industry is rapidly expanding.

Patient education materials of variable quality are being widely marketed in a sophisticated manner. Physicians need to develop skills for the purpose of:

1. Deciding whether to use audiovisual aids;
2. How to use audiovisual aids;
3. How to evaluate audiovisual aids.

B. This seminar consists of three sections:

1. A didactic presentation of the advantages and disadvantages of using audiovisual aids for patient education;
2. A screening and evaluation of at least one patient education film;
3. A group discussion of:
    a. Resident evaluation of the films that were seen;
    b. The use of audiovisual aids in practice.

II. Advantages and Disadvantages of Audiovisual Aids

A. Time

1. The use of audiovisual aids can save the physician and nurse time that would otherwise be needed to present the same information to a large number of people about:
    a. Diseases and conditions: asthma, hypertension, diabetes, low back pain;
    b. Medical regimens: pre- and post-operation breathing exercises, prenatal nutrition, urine testing, contraception;
    c. Procedures: anesthesia, hysterectomy, tonsillectomy, amniocentesis, vasectomy;
    d. Preventive health behavior: smoking cessation, physical fitness, breast self-examination, weight reduction.
2. Individual presentations of audiovisual aids are most easily scheduled just before or after a clinic visit. However, patients who are given new and stressful information during a clinic visit may find it difficult to take in additional information.
3. Extra time is needed to answer any questions a patient might have about the information presented in an audiovisual aid.
4. Screening and evaluating audiovisual aids is a time-consuming process.

B. Cost

1. It is argued that the use of audiovisual aids reduces the cost of patient education by saving valuable physician and nurse time.

2. It may be possible to bill patients and insurance companies for the use of audiovisual aids.

3. Audiovisual aids and equipment are costly. Average prices in 1981 are:

a.	Videocassette	$250
	Video monitor	$300
b.	Eight-millimeter film	$250
	Projector	$400
c.	Filmstrip and cassette	$100
	Film projector with tape player	$525

4. The space required to store audiovisual materials and equipment, and to show audiovisual aids to patients must be considered as an overhead expense.

5. Staff time is necessary for:

    a. Screening, choosing and ordering audiovisual aids and equipment;
    b. Maintaining and operating equipment;
    c. Scheduling patient viewing of audiovisuals;
    d. Answering questions patients have about information presented in an audiovisual aid.

C. Educational Effectiveness

1. Some people find it easier to grasp information that is presented in a visual manner. Through the use of drawings, diagrams and animation, audiovisual aids can provide clear and simple explanations of difficult concepts, such as arteriography or asthma. Audiovisual aids, like television, present information in a way that is visually appealing. Patients may find a film presentation of medical information to be a more palatable method of learning than a written presentation.

2. Audiovisual aids employ visual images as well as spoken and written words to emphasize important concepts. This is an effective method of facilitating patient recall of information.

3. Audiovisual aids can establish a reference group for patients by showing that other people have the same kinds of problems and concerns. A film in which actors who portray heart attack patients discuss common concerns and necessary life style modification during the recovery period may have more impact on a patient than a verbal message from a physician. Patients can identify with the patients in the film who share common experiences.

4. Audiovisual aids can be used with groups as well as with individuals. Because audiovisual aids are generally well produced, they can make a presentation of factual information more interesting and keep the attention of the group.

5. Audiovisual materials are available in Spanish for physicians who have Hispanic patients.

6. Audiovisual aids become outdated rapidly. For example, a film made in 1976 on the treatment of ulcers would have been outdated in 1978. By this time the new drug, cimetidine, had become the treatment of choice for ulcers.

7. Because audiovisual aids are designed for presentation to a large audience, they are not tailored to the needs of an individual patient. The information and instructions given in an audiovisual aid are often too general to be of use to a patient. A videocassette can discuss the importance of weight reduction, exercise, diuretics and reduced salt intake. An audiovisual cannot describe an anti-hypertensive regimen in precise terms, because each patient's regimen varies according to her or his own needs.

8. Audiovisual aids often present more information than a patient can remember or understand at one time. This is especially true when the subject matter is complex.

9. The actors in audiovisual aids are often of a middle class, urban background. Some patients may find it difficult to identify with the actors. Audiovisual companies sell their materials to physicians, not to patients. For this reason, audiovisual aids may not address the needs and concerns of patients: explanations and rationales for treatment choices; methods of coping with a condition and a regimen. Further, audiovisual companies are likely to emphasize the types of information physicians are concerned about: comprehensive and accurate physiological explanations of diseases. It is important to question the perspective of the film. Does it say what the doctor wants to say or what the patient wants to know? For example, a film may use graphics and animation to give a detailed description of the physiology of diabetes, while giving little or no information about a diabetic regimen. It may merely exhort the viewer to "be sure to follow orders and do exactly what the doctor tells you."

10. The treatment plan described in an audiovisual may not be in accord with a physician's approach and recommendations for treatment.

D. Impact of Audiovisual Aids

1. An audiovisual aid may contain all of the information required to ensure informed consent for a procedure. Presentation of an audiovisual aid can facilitate documentation of informed consent.

2. Audiovisual aids may prepare patients for the sensations of a procedure and the symptoms and sensations of a condition or illness as well as of a treatment plan. Such preparation reduces patient anxiety and provides patients with an opportunity to anticipate methods of coping.

3. Audiovisual aids can be useful in preparing children for hospitalization. A movie in which children modeled appropriate hospital behaviors was shown to young patients before a tonsillectomy. The children who saw the movie displayed less anxiety and were discharged earlier than children who did not see the movie (Ferguson, 1979).

4. The use of audiovisual aids has not been shown to increase adherence to therapeutic regimens. In comparison with a control group, hypertensive patients who went through a mastery learning slide tape program did not become more compliant in their use of medications although their knowledge of hypertension did increase (Sackett et al., 1975).

III. Screening and Evaluation of Selected Audiovisual Aids

A. Distribute audiovisual evaluation forms

B. Tell the residents the names of the films and the location of the viewing room for each. Ask them to choose a film to evaluate. Also, describe the viewing procedure:

1. Think of what you would want the film to include;

2. Watch the film;

3. Fill out the audiovisual evaluation form;

4. Return to the seminar room for discussion.

IV. Discussion

A. Encourage the residents to discuss the films they have just seen. Ask questions such as:

1. What did you think of the film you saw?

2. What did you like about it?

3. What didn't you like?

4. How useful would the film be for your patients?

B. Ask residents specific questions from the audiovisual evaluation form.

C. Encourage the residents to discuss their views on using audiovisual aids in practice. Ask questions such as:

   1. Do you plan to use audiovisual aids in practice? Why or why not?

   2. If you use audiovisual aids:

      a. For which topics would you use them?
      b. How would you evaluate and use films?
      c. How would you schedule films?
      d. Would you absorb the cost?
      e. Would you charge patients for the use of audiovisual aids?

AUDIOVISUAL EVALUATION FORM

The evaluation of patient education audiovisuals is a very subjective task. These questions are designed to provide structure to the evaluation process.

Topic ______________________________
Title ______________________________
Format ______________ ______________
Cost ______________________________
Distributor ________________________
Time length ________________________
Date of Publication ________________

* * * * * *

	Yes	No	Comments
I. Purpose (check all that apply)			
A. Provide information about and description of condition.	☐	☐	
B. Description of potential symptoms and consequences of condition.	☐	☐	
C. Preparation for procedures and treatment.	☐	☐	
D. Describe methods of prevention.	☐	☐	
E. Instructions for home treatment.	☐	☐	
II. Content			
A. Is content medically accurate?	☐	☐	
B. Are there useful illustrations?	☐	☐	
C. Is it organized into useful categories?	☐	☐	
D. Does it discuss symptoms/side effects?	☐	☐	
E. Does it anticipate patient difficulties?	☐	☐	
F. Does information justify the treatment?	☐	☐	
G. Does it include irrelevant or an excessive amount of information?	☐	☐	
H. Education level? (Evaluate language used, sophistication of presentation) < 8th Grade ☐ < Highschool ☐ High school + ☐			
III. Instructions			
A. Clear and specific?	☐	☐	
B. Are the instructions in the audiovisuals consistent with the ones you would give to a patient?	☐	☐	
C. Is more than one treatment option presented?	☐	☐	
IV. Bias of Material			
A. Do you agree with the roles assigned to M.D. and patient for prevention and treatment?	☐	☐	
B. Would the portrayal of male & female roles in this movie offend some of your patients?	☐	☐	
C. Would your patients be able to identify with the cultural and economic background of the people portrayed in the movie?	☐	☐	
D. Did you notice other biases? What were they:	☐	☐	
V. Cost Effective			
A. Could this information be presented as effectively in a less expensive format?	☐	☐	

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AUDIOVISUAL EVALUATION FORM

The evaluation of patient education audiovisuals is a very subjective task. These questions are designed to provide structure to the evaluation process.

Topic Essential Hypertension
Format Video
Distributor Slickflicks
Date of Publication 1978

Title High Blood Pressure
Cost $250.00
Time length 15 minutes

• • • • • •

	Yes	No	Comments
I. Purpose (check all that apply)			
A. Provide information about and description of condition.	☒	☐	Too technical.
B. Description of potential symptoms and consequences of condition.	☒	☐	Describes hardening of arteries in scientific terms not human. No discussion of impact or symptoms.
C. Preparation for procedures and treatment.	☒	☐	Names possible components of treatment plan.
D. Describe methods of prevention.	☐	☒	
E. Instructions for home treatment.	☐	☒	"Essential to avoid situations that cause emotional upheaval."
II. Content			
A. Is content medically accurate?	☒ &	☒	
B. Are there useful illustrations?	☐	☒	
C. Is it organized into useful categories?	☐	☒	
D. Does it discuss symptoms/side effects?	☒	☐	Usually no sumptoms. Allusions to side effects; nothing specific.
E. Does it anticipate patient difficulties?	☐	☒	Not at all.
F. Does information justify the treatment?	☐	☒	
G. Does it include irrelevant or an excessive amount of information?	☒	☐	Use of technical terms; unnecessary physiological information.
H. Education level? (Evaluate language used, sophistication of presentation)			
< 8th Grade ☐ < Highschool ☐ High school + ☒			
III Instructions			
A. Clear and specific?	☐	☒	No instructions at all.
B. Are the instructions in the audiovisuals consistent with the ones you would give to a patient?	☐	☒	Mentions use of sedatives and tranquilizers to reduce tension.
C. Is more than one treatment option presented?	☒	☐	
IV. Bias of Material			
A. Do you agree with the roles assigned to M.D. and patient for prevention and treatment?	☐	☒	Narrator continuously tells viewer to faithfully follow doctor's orders.
B. Would the portrayal of male & female roles in this movie offend some of your patients?	☐	☒	
C. Would your patients be able to identify with the cultural and economic background of the people portrayed in the movie?	☐	☒	
D. Did you notice other biases?	☐	☒	
What were they:			

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WRITING PATIENT EDUCATION HANDOUTS:
ACTIVITY FOR MODULE 6

Patient education handouts need to be written, 1) when none are commercially available that address a problem frequently encountered in a specific practice, or 2) when available handouts are inappropriate because of technical language, outdated recommendations or cost.

The development of a good handout takes more time than is immediately evident. The writers should be prepared to go through several revisions to develop a handout which is concise, understandable and individualized to patient needs.

This activity is designed to be done by one or more small groups, but may also be done by an individual resident. As a group activity it has the advantage of allowing residents to share criticisms of existing patient materials and to work together to develop new handouts.

OBJECTIVES

The resident will be able to demonstrate skills in:

1. Identifying content that is appropriate for a patient handout;
2. Recognizing the technical terminology in a handout and modifying it;
3. Organizing the information in a handout in a manner which highlights the important points.

PREPARATION OF THE LEADER

In order to lead this activity, the leader should be familiar with the patient handouts available in the residency. The leader should be alert to language, structure and design in the handouts. Handouts range from the detailed cartoons of the Physicians Art Service to the simple narratives provided by Griffith's Instructions for Patients. Redmond, in The Process of Patient Teaching in Nursing (1972), provides an excellent discussion of the uses of handouts, determining appropriate reading levels, and organizing handouts for readability.

Prior to the seminar or individual activity, the leader should select several topics which would be appropriate for handout development. The topic should be limited in scope and should deal with simple instructions. Writing a handout on the use of a rectal thermometer is much simpler, for example, than writing one on how to lose weight (see Outline, below). It is important to select topics for use in the activity which are manageable and which can be drafted in one or two meetings. After the initial draft is prepared it can be circulated for critiques and revisions.

The leader should collect examples of one or two handouts on each of the topics s/he proposes for development. Critiquing an existing handout makes it easier for the residents to identify information they want to include in the handout and helps them to identify and avoid problems, such as technical terminology. We chose cast care as a topic which needed a better handout in our clinics.

ACTIVITY OUTLINE

I. Introduction - Choosing a Topic

  A. Choose a topic which is dealt with frequently so that the handout meets a patient's need and saves time.

  B. The most effective handouts provide concrete information which the patient will need after the medical encounter, such as:

    1. The normal physiological and sensory process of healing, e.g., care of sutures;

    2. Information about a set of choices that the patient needs to consider prior to a decision, e.g., birth control options;

    3. Instructions about performing some task, e.g., how to use a diaphragm.

  C. Choose a topic which is not adequately addressed by available resources because of:

    1. Cost or availability;

    2. Outdated information or recommendations;

    3. Complexity, medical jargon, or poor format.

  D. Discuss with individuals or a group the choice of topic(s) using the above criteria. Assume that the final product of this activity will be reproduced and used in the clinic practice.

II. Developing a Handout

  A. Review some existing sample(s).

    1. Individuals or the group can informally critique samples or use the Handout Evaluation Form (page 271).

    2. Discuss the critique (following Evaluation Form).

      a. Purpose(s) of the handout.
      b. Content of the handout.
      c. Instructions.
      d. Cost.

3. For the sample handout, "Care and Feeding of Plaster Casts" (page 270), the form might be filled out as the Sample Evaluation Form on page 272.

    a. Problems identified were:

        1. Crowded page, little organization;
        2. Vocabulary, e.g., "macerated and mushy";
        3. Vague and missing instructions.

B. Discuss and define the purpose(s) and content of the handout.

    1. Purpose: For example, taking care of plaster casts, and recognizing and/or preventing problems when wearing a cast.

    2. Content: Developing an outline of important points. The Handout Evaluation Form can be used to ensure that content areas are complete.

C. Write an initial draft, experimenting with format.

    1. Narrative format, as in the sample, often increases difficulty of comprehension. This can be avoided by subject headings or boldface type for important points.

    2. Question and answer format or "Do's and Don'ts" can often help to structure the presentation.

    3. Diagrams should be considered to help elucidate complex concepts or demonstrate proper skills such as back exercises. Illustrations also help to break up the text.

    4. Guidelines for writing include:

        a. Use short, simple sentences;
        b. Avoid medical terms, define those used;
        c. Allow space for individualization;
        d. Be sure all advice is clear and specific.

D. Review the draft, using the handout evaluation form. Make corrections as needed.

E. Designate a person to make a final draft to be typed and reproduced.

III. Discuss the Use of Handouts

A. Handouts should be presented during the medical encounter and any instructions should be reviewed with the patient. Handouts serve as reminders to patients and are not a substitute for good patient education, as developed in earlier Modules.

B. Individualize the information by underlining specific recommendations and by writing any additional suggestions.

C. Follow-up appointments, plans or visits can also be written on the handout to ensure follow-up.

CARE AND FEEDING OF PLASTER CASTS

In addition to its importance in the treatment of your arm or leg, your plaster cast has considerable monetary value. The materials used to make the cast are expensive and the cast deserves proper treatment. Although the plaster bandages are applied wet, water will destroy a cast once it has set. If a little water splashes on the outside, it can be wiped off. If the cast is immersed or if a considerable amount of water gets into the padding between the plaster and your skin, the cast will be destroyed and will have to be replaced. Also, you skin will become macerated and mushy if this occurs.

Localized pressure must be avoided on the cast, especially during the first twenty-four hours. It should not be allowed to rest on sharp edges because this will cause an indentation and a corresponding high spot on the inside of the cast, leading to skin damage.

Only a leg cast with a rubber walking heel is intended for weight bearing. This means no weight on a leg cast without a walking heel. It also means you can't use pressure on an arm cast to help lift yourself out of a chair. Nor can you use the palm of a hand cast as a tool for performing work.

A plaster cast is a lot easier to keep clean than it is to get clean once it is soiled.

Your friend's autographs on the cast will do no harm, but the plaster will ruin a ballpoint pen when it is fresh.

You must also take a few precautions about the arm or leg which is enclosed in the cast. Color, skin temperature, sensation, and motion should all remain fairly normal. Color of the fingers or toes should remain fairly normal. It should neither become too pale--indicating an interference with blood circulation--nor too dark--indicating congestion of blood in the part. The condition being treated with the cast, whether it is a fracture, a sprain, or an operation, naturally results in some swelling. Elevation of the part above heart level will help this. If the swelling becomes excessive, interference with circulation can result and serious complications may result. This applies to the first two or three days only. It is perfectly natural for the fingers or toes to become discolored just as a bruise becomes discolored after several days. This is because the deep bleeding around the fracture, sprain, or operation gravitates downward as the old blood is absorbing.

The fingers or toes should not become too cold. This refers to coldness resulting from a decrease in circulation. An ice bag, even acting through the cast, can help reduce the swelling in an injured part. This could naturally result in some coldness of the fingers or toes which would not necessarily indicate a circulation problem.

The fingers or toes may swell quite a bit after the cast is applied. They should not, however, lose sensation entirely. There may be some decrease in sensation, but light touch sensation ought not disappear.

The fingers and toes should retain their ability to move. They may not move well, but the ability to move them should not be completely lost. Moving the fingers and toes, especially with the part elevated, helps reduce the swelling and also helps minimize the joint stiffness resulting from the period of immobilization. If the color, temperature, sensation, or motion indicate a problem is developing, do not wait for your next appointment. Call for instructions. Do not be afraid to give a detailed description of your problem to my staff. This can be especially important if I am not immediately available. In any case, they can save you a great deal of time and trouble.

HANDOUT EVALUATION FORM

Evaluating patient education handouts is a very subjective task. These questions are designed to help structure the evaluation and to guide the decision making process.

Topic: ______________________

Title: ______________________

Publisher/Author: ____________

Format: ______________________

Cost: ______________________

Publication Date: ____________

		Yes	No	Comments
I.	**PURPOSE**			
A.	Describes and explains the condition?	☐	☐	
B.	Provides information that is essential for carrying out treatment plan?	☐	☐	
C.	Justifies treatment plan?	☐	☐	
D.	Provides information that includes methods of prevention?	☐	☐	
E.	Presents two or more treatment options?	☐	☐	
II.	**CONTENT**			
A.	Medically accurate?	☐	☐	
B.	Are there useful illustrations?	☐	☐	
C.	Is content organized into useful categories?	☐	☐	
D.	Does it discuss symptoms/ side effects and course of condition and treatment plan?	☐	☐	
E.	Does not include irrelevant or excessive information?	☐	☐	
F.	Reading level appropriate for patient population? Evaluate sentence length & terminology: < 8 Grade ☐ < H.S. ☐ H.S. + ☐	☐	☐	
III.	**INSTRUCTIONS**			
A.	Clear and specific?	☐	☐	
B.	Allow room to individualize?	☐	☐	
C.	Identifies and problem solves potential barriers to adherence?	☐	☐	
IV.	**COST EFFECTIVE**			
A.	Is information presented effectively in the least expensive format?	☐	☐	

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SAMPLE

HANDOUT EVALUATION FORM

Evaluating patient education handouts is a very subjective task. These questions are designed to help structure the evaluation and to guide the decision making process.

Topic: *Cast Care*

Format: *Xerox copy*

Title: *"Care and Feeding of Plaster Casts"*

Cost: *.03¢*

Publisher/Author: *Clinic*

Publication Date: *?*

		Yes	No	Comments
I.	**PURPOSE**			
A.	Describes and explains the condition?	☒	☐	
B.	Provides information that is essential for carrying out treatment plan?	☒	☐	
C.	Justifies treatment plan?	☒	☐	*Water destroys plaster.*
D.	Provides information that includes methods of prevention?	☐	☒	*Indentation can damage skin.*
E.	Presents two or more treatment options?	☐	☒	
II.	**CONTENT**			
A.	Medically accurate?	☒	☐	
B.	Are there useful illustrations?	☐	☒	
C.	Is content organized into useful categories?	☐	☒	*Difficult to read - no major points. Crowded.*
D.	Does it discuss symptoms/side effects and course of condition and treatment plan?	☒	☒	*Omits itching, which is common.*
E.	Does not include irrelevant or excessive information?	☒	☐	*Too much information on discoloration. Autographs?*
F.	Reading level appropriate for patient population? Evaluate sentence length & terminology: < 8 Grade ☐ < H.S. ☒ H.S. + ☐	☐	☒	*"macerated and mushy"?* *"localized pressure"* *"light touch sensation"*
III.	**INSTRUCTIONS**			
A.	Clear and specific?	☐	☒	*Vague - what's too pale or too dark?*
B.	Allow room to individualize?	☐	☒	
C.	Identifies and problem solves potential barriers to adherence?	☒	☒	*1) ice bag for swelling (+)* *2) omits itching (-)*
IV.	**COST EFFECTIVE**			
A.	Is information presented effectively in the least expensive format?	☐	☒	

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DEVELOPING A HANDOUT DISTRIBUTION SYSTEM FOR A GROUP PRACTICE: ACTIVITY FOR MODULE 6

When handouts are easily accessible to the physicians and clinic staff they are frequently used. In addition, no time is wasted running down the hall for the right booklet. The question which arises, then, is how to design and implement an efficient handout distribution system.

It is our observation that a handout distribution system works best when a selection of commonly used handouts are filed in each examining room and in the consultation office (if it exists). The more convenient these files are the better; a file drawer of a desk is ideal. A problem arises, especially in a group practice, in determining what topics should be included in the file.

This activity is designed to be done by an interested individual or individuals. Its purpose is to set up a handout distribution system. Other residents also learn from this project, for they are called on to express their preferences for handout inclusions, and they benefit from the system when it is set up.

OBJECTIVES

The resident will be able to demonstrate skills in:

1. Designing a working handout distribution system;
2. Selecting, by group process, frequently used handouts.
3. Evaluating the effectiveness of their system by satisfaction questionnaire or handout count.

PREPARATION OF THE LEADER

It is the leader's task to assure that the handout distribution system gets off the ground. This may include assisting in developing supplies of necessary handouts, helping delegate the task of keeping the files filled to interested clinic staff, or providing support in discussions with clinic directors, other staff and residents.

The selection of topics to be included in the file can be determined by group discussion or by questionnaire to residents, staff physicians and nurse practitioners. The questionnaire may be preferable, because it allows the respondent the opportunity to think about her or his choices and to select from a wide range of topics. Group discussion can follow the presentation of the questionnaire results.

PREPARATION OF THE RESIDENTS

The resident(s) who participate in this activity must be willing to commit time to determining the logistics of a handout distribution system, negotiating with administrators, ordering some materials, and delegating ongoing responsibilities, as well as determining the topics for inclusion in the system.

ACTIVITY OUTLINE

I. Prepare the Questionnaire. The questionnaire to determine topics for the handout system should be distributed to all primary health care providers in the clinic. The questionnaire might provide a list of topics and ask:

  A. For which 15 topics do you most frequently use patient education handouts?

  B. Which specific handouts do you use?

  C. For example, a survey done at one of our clinics produced the following list of patient education handouts for each room:

    1. Anxiety and depression

    2. Breast self-exam

      a. Breast self-exam pamphlets
      b. Fibrocystic disease

    3. Contraception

      a. Anatomical drawings
      b. Available methods of birth control
      c. The pill
      d. Diaphragm
      e. IUD - information and instruction sheets
      f. Birth control handbook

    4. Dermatology

      a. Acne
      b. Impetigo
      c. Eczema
      d. Lice/Scabies

    5. Diagnostic tests and preps

      a. Hemoccult slide test
      b. Glucose tolerance test
      c. 2 Hour P.P. blood sugar test

6. Diets
    a. Diet diary
    b. Ideal body weight
    c. Low sodium
    d. High fiber

7. Fertility control
    a. Abortion
    b. Basal body temperature
    c. Vasectomy

8. Fever

9. Gastro-intestinal tract
    a. Vomiting and diarrhea

10. Immunization
    a. Tine
    b. PPD
    c. Polio
    d. M-M-R
    e. DPT

11. Low back pain

12. Otitis media

13. Smoking

14. Upper respiratory illnesses
    a. Common cold
    b. Pharyngitis / Tonsillitis
    c. Strep throat information

15. Urinary tract infection

16. Vaginal infections and exercises
    a. Vaginal exercises
    b. Avoiding episiotomies
    c. Vaginal infections

17. Venereal disease

II. When topics have been identified by the questionnaire and handouts for each topic are assembled, decide on a convenient location for each set of handouts.

   A. In one of our clinics, a set was placed in the desk drawer in each examining room.

   B. Alternatives are wall mounted file folders, or a centrally located file.

III. Evaluation of the System. The resident(s) involved should design an evaluation of the distribution system. This should include comparisons before and after the system is established. The evaluation can compare:

   A. Resident satisfaction with their ability to efficiently use patient education handouts.

   B. The number of handouts given out in a week.

   C. The percentage of patients with a specified problem receiving appropriate handouts during a week.

IV. If little or no change is seen, the activity should be repeated to re-evaluate the revised system.

THE ROLE OF THE CLINICAL FACULTY FOR MODULE 6

The model clinic serves as a laboratory for the resident to try out techniques of patient education under the supervision of the clinical faculty physicians and nurses. In this setting the resident develops habits in the use of pamphlets, handouts and films, and develops her or his ideas about the coordination of patient education with nurse practitioners and other care providers. The organization of patient education in practice is best taught when the clinic offers the resident a variety of models of materials use and staff support.

The experienced physician has preferences for certain instructional materials and referral patterns and has developed habits about their use. These preferences and habits are the focus of Module 6. The activities in Module 6 are designed to teach the resident to:

1. Develop patient education handouts;
2. Use explicit criteria to evaluate commercially prepared patient education resources such as films and pamphlets;
3. Select instructional materials appropriate for the patient;
4. Develop systems to facilitate the use of patient education materials in office practice.

Module 6 differs from the earlier modules in that the skills it teaches are removed from the clinical encounter. Faculty input is more likely to occur in clinic meetings or informal case discussions than in direct observation and staffing exchanges.

METHODS OF TEACHING PATIENT EDUCATION SKILLS IN THE OUTPATIENT CLINIC

1. *Develop patient education handouts.*

The physician or nurse often is aware of a need to develop a patient education handout when s/he repeatedly confronts patients with similar problems and similar informational needs. The patients' problem may be simple, such as the need for a calendar or grid to serve as a reminder to take all the dosages of an antibiotic regimen, or more complicated, such as the need to understand the requirements of cast care. In either case, the handout developed must directly address the patients problems and present strategies to assist her or him in coping with anticipated problems.

When seeing a patient with a resident, you can help the resident identify patients with problems which could be helped by the use of a handout. Patients with routine problems which require a number of discrete steps for treatment are often assisted by handouts. These include parents learning to take a rectal temperature, patients instructed to prepare a three day stool test for occult blood, women learning the procedure for use of a diaphragm, or patients recovering from minor surgical procedures. Handouts for these patients are relatively easy to prepare and may later save time in follow-up phone calls or repeat visits.

When discussing a patient with a resident, you can ask the resident to specify the information s/he would want to be sure to include in a handout for patients with similar problems. A list of information prepared this way can form the first draft of a handout. From this you can suggest that the resident write up a handout following the guidelines in the activity on the development of handouts on page 266.

2. *Using explicit criteria, evaluate commercially prepared patient education materials, such as films and pamphlets.*

Quality patient education materials are medically accurate, clearly organized, and allow room for individualization to patient needs. Materials should also be appropriate to the patient audience. Booklets about birth control for young teenagers, for example, neea to take a different approach than booklets for older, more sophisticated patients. All commercially prepared patient education materials do not meet uniform standards of quality.

When seeing a patient with a resident, you can suggest the use of a specific pamphlet and indicate the criteria you used to evaluate it. You might later reinforce the use of explicit criteria for evaluating materials by asking the resident to review a number of pamphlets or films on a particular problem for the patient education file. You can suggest that s/he choose several pamphlets or films appropriate to different audiences.

When discussing patients with a small group of residents, ask them what booklets or audiovisual aids they would use with the patient. If the residents would use different materials, ask them why they chose the ones they did. In your discussion, be specific about issues of medical accuracy, organization of the material and opportunities for individualization and reinforcement.

3. *Select instructional materials appropriate for the patient, e.g., labeling of drug containers, pamphlets, films, instruction sheets, etc.*

Once a clinic has established a stock of quality educational materials, the practitioner must choose those most appropriate for each individual patient. In choosing materials for a patient the practitioner can consider her or his age and sex, level of medical understanding, need for information, and her or his preferred learning style. When asked, many patients will tell the physician whether they prefer to read a pamphlet or see a film, or whether they think referral to a nurse practitioner would be helpful to them.

When seeing a patient with a resident, you can ask the patient questions which are designed to assess her/his educational needs and preferences: "Do you feel that you have enough factual knowledge about your diet? Do you think that discussing with a nurse practitioner your problems in changing your diet would help you now?" Given the patient's responses you can suggest instructional materials to the resident. As before, try to explain your selection with the criteria you used.

4. *Develop systems to facilitate the use of patient education materials in office practice.*

In order for patient education materials to be effectively used, they need to be easily accessible. In some clinic practices a central file of handouts and pamphlets is conveniently located to serve all treatment rooms. However, patient education materials for very common problems are generally used more frequently if they are located in each examining room.

When seeing a patient with a resident, you can demonstrate the importance of conveniently located materials by suggesting a handout which you know is included in the examining room file. For example, a handout on cast care should be readily available in the casting room. When a resident does a casting procedure, you can then suggest that the handout be given to the patient.

Similarly, when discussing a patient with the resident, suggest written materials where appropriate, such as back exercises. If the resident explains that the handout was not in the file or was too inconvenient or difficult to find, discuss ways to reorganize or update the file system. Suggest that the resident take responsibility for following through on the plan that you discuss. The clinic practice can then have continuous review of its patient education materials system and the resident can see the importance of easily accessible materials in everyday practice.

BIBLIOGRAPHY

Aiken, L. Chronic illness and responsive ambulatory care. In Mechanic, D., The Growth of Bureaucratic Medicine. N.Y.:John Wiley & Sons, 1976.

Becker, M.H. (ed.) The health belief models and personal health behavior. Health Education Monographs 3(4), 1974.

Bosshart, D. Selection and evaluation of resources in patient education. In Currie, B. (ed.), Patient Education in the Primary Care Setting: Proceedings of a Conference. Dept. Family Medicine, U.W.-Madison, pp. 103-111, 1977.

Bradshaw, P.W., Ley, P., Kincey, J.A. and Bradshaw, J. Recall of medical advice: Comprehensibility and specificity. British Journal of Social and Clinical Psychology, 14:55-62, 1975.

Bruhn, J. Effects of chronic illness on the family. J. of Fam. Practice, 4(6):1057-1060, 1977.

Canadian Task Force on the Periodic Health Examination. Task Force Report: The periodic health examination. Canadian Med. Assoc. J., 121:1-45, (Nov. 3) 1979.

Caron, H. and Roth, H. Patients' cooperation with a medical regimen: Difficulties in identifying the noncooperator. JAMA, 203:120, (Mar. 11) 1968.

Crichton, E.F., Smith, D.L. and Demanuel, F. Patient recall of medication information. Drug Intell. Clin. Pharm., 12:591-599, (Oct.) 1978.

Danaher, B., Ellis, B. and Farquhar, J. How to help smokers who want to quit. Patient Care, 14:86-122, (Aug. 15) 1980.

Egbert, L. Reduction of postoperative pain by encouragement and instruction of patients. New Engl. J. Med., 270:825-827, 1964.

Enelow, A. and Swisher, S. Interviewing and Patient Care (2nd ed.). New York:Oxford University Press, 1979.

Espenshade, J. Staff Manual for Teaching Patients about Diabetes Mellitus. Chicago:Amer. Hosp. Assoc., 1979.

Fass, M., et al. The effect of family education on patient adherence to anti-hypertensive regiemns. Paper presented at the National High Blood Pressure Control Conference, Wasington, D.C., April, 1977.

Ferguson, B. Preparing young children for hospitalization: A comparison of two methods. Pediatrics, 24(5):656-664, 1979.

Fink, D. Tailoring a consensus regimen. In Sackett, D. and Haynes R. (eds.), Compliance with Therapeutic Regimens. Baltimore:Johns Hopkins Press, 1976.

Finnerty, F., Mattie, E., and Finnerty, F. Hypertension in the inner city: I. Analysis of dropouts. Circulation, 47:76-78, 1973.

Francis, V., Korsch, B. and Morris, M. Gaps in doctor-patient communication: Patients response to medical advice. New Engl. J. Med., 280:535, (March 6) 1969.

Gordis, L., Markowitz, M. and Lilienfeld, A. Studies in the epidemiology and preventability of rheumatic fever. IV. A quantitative determination of compliance in children on oral penicillin prophylaxis. Pediatrics, 43:173-82, 1969.

Griffith, H. Instructions for Patients (2nd ed.). Philadelphia: Saunders, 1975.

Haynes, R., Taylor, D. and Sackett, D. (eds.). Compliance in Health Care. Baltimore, MD:Johns Hopkins U. Press, 1979.

Hogue, C. Nursing and compliance. In Haynes, R.B., Taylor, D.W. and Sackett, D.L. (eds.), Compliance in Health Care. Baltimore, MD: Johns Hopkins U. Press, pp. 247-259, 1979.

Horn, D. Smoker's Self-Testing Kit, Test III. DHEW Publication No. (NIH) 79-1822. U.S. Dept. Health, Ed & Welfare, 1979.

Hulka, B., Cassel, J., Lawrence, L. and Burdette, J. Communications, compliance and concordance between physicians and patients with prescribed medication. Am. J. Public Health, 66:847-853, 1976.

Hulka, B., Kupper, C., Cassel, J. and Mayo, F. Doctor-patient communication and outcomes among diabetic patients. J. Community Health, 1:15, 1975.

Johnson, J. Kirchoff, K. and Endress, M. Deterring children's distress behavior during orthopedic cast removal. Nurs. Res., 75:404-410, 1975.

Johnson, J. and Leventhal, H. Effects of accurate expectations and behavioral instructions on reactions during a noxious medical examination. J. Pers. Soc. Psychol., 29:710-718, 1974.

Johnson, J., Leventhal, H. and Dabbs, J. Contributions of emotional and instrumental response processes in adaptation to surgery. J. Pers. Soc. Psychol., 2:55-64, 1971.

Johnson, J., Morissey, J. and Leventhal, H. Psychological preparation for an endoscopic examination. Gastrointest. Endosc., 19:180-182, 1973.

Johnson, J. Effects of structuring patients' expectations on their reactions to threatening events. Nursing Research, 21:499-504, 1972.

Johnson, J. Effects of accurate expectations about sensations on the sensory and distress components of pain. J. Pers. Soc. Psychol., 27:261-275, 1973.

Joyce, C., Caple, G., Mason, M., Reynolds, E. and Mathews, J. Quantitative study of doctor-patient communication. Quarterly J. Med., 38:183-194, 1969.

Korsch, B., Freemon, B. and Negrete, V. Practical implications of doctor-patient interactions: Analysis for pediatric practice. Amer. J. Diseases of Children, 121:110-114, 1971.

Korsch, B, Gozzi, E. and Francis, V. Gaps in doctor-patient communication. Pediatrics, 42:855-871, 1968.

Lear, M. Heartsounds. New York:Simon and Schuster, 1980.

Leventhal, H. The consequences of depersonalization during illness and treatment. In Howard, J. and Strauss, A. (eds.), Humanizing Health Care. New York:Wiley, 1975.

Leventhal, H. and Cleary, P. The smoking problem: A review of the research and theory in behavioral risk modification. Psych. Bull., 1980 in press.

Leventhal, H. and Johnson, J. Laboratory and field experimentation: Development of a theory of self-regulation. In Leonard, R. and Wooldridge, P. (eds.), Behavioral Science and Nursing Theory. St. Louis, MO: C.V. Mosby, 1980.

Leventhal, H., Meyer, D. and Nerenz, D. The common sense representation of illness danger. In Rachman, S. (ed.), Medical Psychology, Vol. 2., New York: Pergamon, 1980.

Leventhal, H., Singer, R. and Jones, S. Effects of fear and specificity of recommendations upon attitudes and behavior. J. Pers. Soc. Psychol., 2:20-29, 1965.

Levine, D., et al. Health education for hypertensive patients. JAMA, 241:1700-1703, 1978.

Levy, R., Yamashita, D. and Pow, G. Relationship of an overt commitment to the frequency and speed of compliance with symptom reporting. Med. Care, 17(3):281-284, 1979.

Ley, P. Memory aspects of doctor-patient communication. University of Liverpool, unpublished Ph.D. Thesis, 1969.

Ley, P. Primacy, rated importance and recall of medical information, J. Health Soc. Behav., 13:311-317, 1972.

Ley, P. Psychological studies of doctor-patient communication. In Rachman, S. (ed.), Contributions to Medical Psychology, Vol. 1, Oxford: Pergamon, 1977.

Ley, P., Bradshaw, P., Kincey, J., Couper-Smartt, L. and Wilson, M. Psychological variables in weight control. In Burland, W., Samuel, P. and Yudkin, J. (eds.), Obesity. London:Churchill-Livingstone, 1974.

Ley, P., Bradshaw, P., Kincey, J. and Atherton, S. Increasing patients' satisfaction with communication. British J. Soc. Clin. Psych., 15:403-413, 1976.

Ley, P., Jain, V. and Skilbeck, C. A method of decreasing medication errors made by patients. Psych. Med., 6:599-601, 1976.

Mahoney, M.J. and Mahoney, K. Permanent Weight Control. New York:W.W. Norton, 1976.

Mahoney, M. and Thoresen, C. Self-Control: Power to the Person. Monterey, CA:Brooks/Cole, 1974.

Mattar, M., Markello, J. and Yaffe, S. Inadequacies in the pharmacologic management of ambulatory children. Pediatrics, 87:137-141, 1975.

McKenney, J., Slining, J., Henderson, H., Devins, D. and Barr, M. The effect of clinical pharmacy services on patients with essential hypertension. Circulation, 48:1104-1111, 1973.

McKinley, J. Who is really ignorant - physician or patient? J. Health Soc. Behav., 16(1):3-11, 1975.

Melamed, B. Psychological preparation for hospitalization. In Rachman, S. (ed.), Contributions to Medical Psychology, Vol. 1. New York: Pergamon Press, 1977.

Meyer, D. The effects of patients' representation of high blood pressure on behavior in treatment. Unpublished doctoral dissertation, Univ. of Wisconsin-Madison, 1981.

Mullen, P. Cutting back after a heart attack: An overview. Health Educ. Mono., 6(3):295-311, 1978.

National Task Force on Training Family Physicians in Patient Education. Patient Education: A Handbook for Teachers. Kansas City:STFM, 1979.

Nerenz, D. Control of emotional distress in cancer chemotherapy. Unpublished doctoral dissertation, Univ. of Wisconsin-Madison, 1979.

Office of Cancer Communications, NCI. The Smoking Digest. Bethesda, MD: NIH National Cancer Institute, 1977.

Owen, B. Coping with chronic illness. Amer. J. Nurs., 75(6):1016-1018, 1975.

Platt, F. and McMath, J. Clinical hypocompetence: The interview. Ann. Intern. Med., 91:898-902, 1979.

Podell, R. Physician's Guide to Compliance in Hypertension. Rahway, NJ: Merck & Co., Inc., 1975. Also reprinted in Preventive Medicine, U.S.A. Health Promotion and Consumer Health Education: Task Force Report of J.E. Fogarty International Center for Advanced Study in Health Sciences, NIH and American College of Preventive Medicine. Prodist, NY, 1976.

Preventive Medicine, U.S.A. *Health Promotion and Consumer Health Education*: Task Force Report of J.E. Fogarty International Center for Advanced Study in Health Sciences, NIH and American College of Preventive Medicine. Prodist, NY, 1976.

Redmond, B. *The Process of Patient Teaching in Nursing* (3rd ed.). St. Louis: C.V. Mosby, 1976.

Sackett, D. A compliance practicum for the busy practitioner. In Haynes, R., Taylor, D. and Sackett, D. (eds.), *Compliance in Health Care*. Baltimore:Johns Hopkins U. Press, pp. 286-294, 1979.

Sackett, D. Future applications and hypotheses from old research. Prepared for the conference on "New Directions in Patient Compliance." Indiana:French Lick, Aug. 8-10, 1978.

Sackett, D. and Haynes, B. *Compliance with Therapeutic Regimens*. Baltimore: Johns Hopkins U. Press, 1976.

Sackett, D., et al. Randomized clinical trial of strategies for improving medication compliance in primary hypertension. *Lancet*, 1(7918):1205-1207, 1975.

Safer, M., Tharps, Q., Jackson, T. and Leventhal, H. Determinants of three stages of delay in seeking care at a medical clinic. *Med. Care*, 17:11-29, 1979.

Samora, J., Saunders, L. and Larson, R. Medical vocabulary knowledge among hospital patients. *J. Health Human Behav.*, 2(Summer):83-92, 1961.

Schmitt, F. and Wooldridge, P. Psychological preparation of surgical patients. *Nurs. Res.*, 22:108-115, 1973.

Schulman, B. Active patient orientation and outcomes in hypertensive treatment: Application of a socio-organizational perspective. *Med. Care*, 17(3):267-280, 1979.

Sharpe, T. and Mikeal, R. Patient compliance with antibiotic regimens. *Am. J. Hosp. Pharm.*, 31:479-484, 1974.

Skipper, J. and Leonard, R. Children, stress and hospitalization: A field experiment. *J. Health Soc. Behav.*, 9:257-287, 1968.

Steckel, S. and Swain, M. The use of written contracts to increase adherence. *Hospitals*, 51(23):81, 1977.

Sternburg, J. and Brockway, B. Evaluation of clinical skills: An asset oriented approach. *J. Fam. Prac.*, 8:1243-1245, 1979.

Strauss, A. *Chronic Illness and the Quality of Life*. St. Louis:C.V. Mosby, 1975.

Stuart, R. and Davis, B. *Slim Chance in a Fat World: Behavioral Control of Obesity*. Champaign, IL:Research Press, 1972.

Svarstad, B. The doctor-patient encounter: An observational study of communication and outcome. Unpublished Doctoral Dissertation, Department of Sociology, University of Wisconsin, 1974.

Svarstad, B. Physician-patient communication and patient conformity with medical advice. In Mechanic, D. (ed.), The Growth of Bureaucratic Medicine. New York:John Wiley & Sons, pp. 220-238, 1976.

Svarstad, B. and Lipton, H. Informing patients about mental retardation: A study of professonal communication and parent acceptance. Soc. Sci. and Med., 11(11):645-652, 1979.

Swain, M. Experimental interventions to promote health among hypertensives. Paper presented at APA meeting, Toronto, Canada, 1978.

Swain, M. Final Report of a Grant to Evaluate Effects of Written Contracting on Adherence to Antihypertensive Treatment. Washington, DC: DHEW, NIH, 1980.

Tagliacozzo, D. and Ima, K. Knowledge of illness as a predictor of patient behavior. J. Chronic Dis., 22:765, 1970.

Thoresen, C. and Mahoney, M. Behavioral Self-Control. New York:Holt, Rinehart and Winston, 1974.

Watkins, J., et al. A study of diabetic patients at home. Am. J. Pub. Health, 57:452, 1967.

Williamson, J. and Danaher, K. Self-Care in Health. London:Croom Helms, 1978.

Zborowski, M. Cultural components in response to pain. J. Soc. Issues, 8:16, 1952.